

**DEPARTMENT OF DEFENSE APPROPRIATIONS FOR
FISCAL YEAR 1990**

HEARINGS

BEFORE A

**SUBCOMMITTEE OF THE
COMMITTEE ON APPROPRIATIONS
UNITED STATES SENATE**

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

H.R. 3072

**AN ACT MAKING APPROPRIATIONS FOR THE DEPARTMENT OF DE-
FENSE FOR THE FISCAL YEAR ENDING SEPTEMBER 30, 1990, AND FOR
OTHER PURPOSES**

PART 5 (Pages 1-364)

**ARMY MEDICAL ISSUES
ENLISTED PERSONNEL ISSUES
MANPOWER OVERVIEW
MEDICAL READINESS**

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DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 1990

THURSDAY, JUNE 8, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9 a.m. in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (Chairman) presiding.
Present: Senators Inouye, Stevens, Garn, and Kasten.

DEPARTMENT OF DEFENSE

MANPOWER OVERVIEW

STATEMENT OF DAVID J. BERTEAU, DEPUTY ASSISTANT SECRETARY OF
DEFENSE FOR RESOURCE MANAGEMENT AND SUPPORT

OPENING STATEMENT OF SENATOR INOUE

Senator INOUE. This morning the Subcommittee on Defense Appropriations will hear from Mr. David J. Berteau, the Acting Assistant Secretary of Defense for Force Management and Personnel. Mr. Berteau will offer the subcommittee an overview of manpower and personnel issues in the fiscal year 1990 amended budget for the Department of Defense.

During the previous hearings I have tried to make it quite clear that my principal concerns as the chairman of this subcommittee are the welfare of the men and women, military and civilian, who serve in the Department of Defense. I want to reiterate my support for these public servants this morning.

From the dismal period of the late 1970's and early 1980's, when all the military services were suffering from shortfalls in manpower, both in quality and quantity, when the Army was characterized by its own Chief of Staff as a hollow Army, and when the Navy was having difficulty manning its ships, the military has come a long way.

Through cooperation between the Congress and the Executive branch, and with the support of the American taxpayer, these problems largely have been corrected. The present looks much brighter than the past. The military services are stronger today than at any time in recent history. The quality of personnel is good, generous benefits are provided, and training has improved.

I believe that through continued cooperation between our two branches of Government we can assure that the 1.2 million men and women in uniform serving in the active armed services and

the 1.2 million in the Guard and Reserves will receive the resources that they need to defend our country and protect our national interest.

In support of our military forces and uniformed personnel the Department of Defense employs 1.1 million civilians, approximately half of all Federal civilian personnel. Civilian personnel is an area of new management challenges. As civil service salaries and benefits have been held down because of deficit pressures, it is becoming increasingly important to motivate our civilian work force to increase productivity.

We must ensure that highly qualified young people continue to view Federal service as a meaningful and challenging career, and we must find ways to meet critical skill shortfalls such as those in the civilian health care but offering competitive compensation.

Mr. Secretary, it is a pleasure to have you appear before us this morning. With your background as a member of the Packard Commission staff and the Office of the Department of Defense comptroller, and as an assistant to former Deputy Secretary Taft, you have built a solid reputation as a defense manpower expert and as one who is knowledgeable of the relationship between personnel problems and the overall readiness of our armed forces.

Once again, welcome, sir. We have received your full statement and, without objection, it will be made part of the record in total and you may proceed as you wish, sir.

Mr. BERTEAU. Thank you, Mr. Chairman. I appreciate that. I have a few words I would like to say as an opening statement.

I also want to thank you for your support and the words that you spoke with respect to the success and the need for continued support for our people. It has truly been one of the success stories of this decade and we need to continue to build on the progress that we have made.

I would like to emphasize today what Secretary Cheney has noted repeatedly, that the maintenance of quality, well-trained personnel is his top priority. The budget that we have submitted we believe is the best match of manpower, force structure and reduced budgets that we could come up with, and we urge this committee's support for the priorities that are reflected in that revised budget.

Mr. Chairman, we also urge your continued support to produce authorization and appropriation bills on schedule. Last year was a welcome change, both for you, I am sure, and for us, as well as to move toward biennial budgets. The stability provided by these actions has payoffs in all areas of the defense budget.

MANPOWER REQUIREMENTS

The fiscal year 1990 revised budget submission maintains the appropriate mix of total force personnel—active, reserve, civilians, et cetera—and shows the continued exercise of productivity improvements throughout the Department.

We are able today to meet manpower requirements despite the tight fiscal constraints. And this mix needs to be continually adjusted for changes in workloads and missions. Let me highlight the force structure and manpower reductions that we took in this fiscal year 1990 budget.

For the active duty military, the 1990 total end strength is reduced by more than 11,000 from the programmed 1989 position and by 16,700 from the original 1990 budget. The Army reduction, 7,400, takes a brigade out of the 4th Infantry Division and reduces forces in Europe based on the INF Treaty. Air Force reductions in 1990 reflect bomber and fighter reductions and some contracting-out actions. The Navy, of course, has reduced carrier battle groups from 15 to 14, 4 transferred frigates to the reserves, is decommissioning 11 destroyers, while increasing Navy SEAL platoons and Navy health care personnel. In addition, the Navy forgoes a planned increase of 4,400 in 1990 active duty end strength. For 1991, the active military end strength is reduced for all of DOD by another 1,400 spaces from 1990.

The selected reserve meanwhile continues to increase, although at a slower pace—7,500 from 1989 to 1990, and an additional 4,000 in 1991. This is still a small reduction from the original 1990 and 1991 proposals.

Our civilian end strength, as you noted, is about 1.1 million in 1990, with a reduction of an additional 3,000 end strength for 1991. This is about 5,200 civilian spaces below the 1989 numbers, so we are seeing a downward trend in civilians as well.

We have had a number of successful efforts to refine our oversight of manpower requirements over the past 2 years for both military and civilian. I have gone into some detail on these in my written statement. There is only one that I would like to highlight this morning, and that is the study of the unified and specified command headquarters.

In December 1987, Secretary Carlucci directed this review, which has become known as the Vander Schaaf report. The report recommended specific headquarters reductions and the secretary and the chairman of the Joint Chiefs approved the reduction of almost 3,000 military and civilian spaces based on that report.

They further agreed to reinvest over 2,200 of those spaces to satisfy unfilled requirements in combat, medical support, and drug interdiction operations. These actions are already reflected in the 1990 budgets.

As we continue to improve our requirements determination processes we need your help in supporting the projects in our productivity investment fund, which provide for capital investment that pays back in savings, usually in less than 2 years.

You can also help by removing legislated personnel ceilings. These ceilings prevent us from matching our missions and workloads with the manpower we need and reduce our ability to manage our forces in the most cost-effective way.

The Department over the past few years has demonstrated its ability to manage civilians effectively without a legislatively imposed civilian ceiling, and we ask your support in letting us do that by removing, for example, the ceiling on civilians overseas.

MILITARY REQUIREMENTS

In recruiting, our results from the first half of 1989 show that the military services are still meeting or exceeding their objectives,

but there are some emerging signs of concern. My written statement also goes into considerable detail on that.

In order to preserve the continued success that we have had in recruiting, we do need your strong support for the recruiting initiatives that are in the fiscal year 1990 revised budget, including the supplemental education benefits, the advertising money, the recruiting facilities, and the adjustment of the ceilings on recruiting incentives.

Most importantly, of course, we need to protect the 3.6 percent military pay raise, because that compensation is one of the best recruiting incentives that we have.

The All-Volunteer Force is working, and every analysis shows that to sustain a force of the same quality as we have today under a compulsory military service or national service would cost more than the current all-volunteer system. Because the volunteer force has been shown to be highly effective and because we have clearly demonstrated the ability to attract the number and quality of people we will need during the next decade, there is no need for either a peacetime draft or a compulsory national service to satisfy any military manpower requirements.

There is, rather, a strong need to sustain our success by restoring and maintaining the value of the resources and the incentives for recruiting and retention, maintaining the purchasing power and the competitive appeal of military compensation and sustaining the political support for our armed forces that has been such a key ingredient to our success. We request your continued support in doing this.

MILITARY TRAINING

Let me turn just briefly to a couple of other areas of the budget. One is training. The training of our military personnel and operational units has improved remarkably during the past few years, and we have held the line on all those in the revised 1990 budget.

Most of the operating tempos in the President's budget are at the same levels in 1990 and 1991 as in previous years, and this took some considerable doing within the budget reductions that we went through to preserve these OPTEMPOS. We need your continued support for this.

MILITARY RETENTION

Another area of concern, of course, is our projected shortages in pilots, nuclear officers, medical personnel, as well as in certain mission-critical enlisted areas. They will require continued attention.

Overall, our enlisted retention rates remain satisfactory, but most are now several percentage points below the highs that we had in the 1982 to 1984 timeframe. The maintenance of incentive programs will be vital to retaining the proper mix of officer and enlisted experience and skills.

The enlistment and selective reenlistment bonus programs will continue at relatively austere levels in 1989 and 1990. Any reductions beyond those now programmed may further limit our ability to maintain our mission-critical skills and to react quickly in the

event of a retention downturn. We ask, of course, for your strong support for these cost-effective bonus programs.

Monetary incentives will be particularly important in retaining critical officer skills, including, as I mentioned, the aviators, the physicians, and the nuclear-trained officers, where we do face continuing shortages.

VARIABLE HOUSING ALLOWANCE

We appreciate the funding increase approved by Congress for the variable housing allowance program in 1989. This did enable us to provide rate increases in those housing areas where members are experiencing the greatest cost growth. However, a funding ceiling was again imposed on the program in 1989. For 1990, we are asking for two things—a 3.6-percent increase in the variable housing allowance rate, and we are hopeful the Congress will not impose a ceiling on that again.

Mr. Chairman, let me summarize by saying we have made great strides in the manpower area in the last 7 years, and this committee has been instrumental in the improvements made in personnel quality and readiness. In this year of reduced budgets the manpower and personnel concerns of the Defense Department will be particularly vulnerable and will present great challenges both to the Department and to the Congress.

I ask for your help in ensuring that the significant progress that has been made not be undone. Our continued success depends on your support for adequate recruiting resources and incentives, for compensation and for quality of life for our defense family as well as for the overall program we have built for 1990 and 1991.

I would like to conclude my opening remarks at that point, Mr. Chairman, and respond, if I may, to any questions you may have.

[The prepared statement follows:]

STATEMENT OF DAVID J. BERTEAU

I. Introduction

Mr. Chairman, thank you for the opportunity to appear before this subcommittee to discuss the DoD revised manpower budget for FYs 1990-1991. Secretary Cheney has noted repeatedly that the maintenance of quality, well-trained personnel is his top priority. The reductions we have taken in the FYs 1990-1991 revised budget have protected a force that is ready and well-trained. Through specific force structure reductions, the residual force remains the best match of manpower, force structure, and reduced budgets. We urge this subcommittee's support for the priorities reflected in the revised budget.

We also urge your continued support for efforts to produce authorization and appropriation bills on schedule, and for our continued attempts to move toward biennial budgets. The stability provided by these actions has payoffs in all areas of DoD--from selective reenlistment bonuses to total force oversight, from OPTEMPO to tank procurement.

Since the quality and the well-being of our uniformed and civilian personnel, with an appropriate overall level of readiness, were our highest priorities in developing this budget, I will focus my statement today on our management of the life cycle of the total force--requirements determination, recruiting, training, utilization, and retention--and on how our revised budget relates to that management.

The U.S. relies on the capabilities of its total force for peacetime deterrence and wartime success. The total force is composed of active and reserve forces, military retirees, DoD civilians, host-nation support, and contracted services. By maintaining an appropriate mix of these personnel, we are able to meet total manpower requirements under tight fiscal constraints. This mix must continually be adjusted in response to changes in the Department's peacetime work loads and wartime missions.

Our overall objective is to use the most cost-effective mix of personnel that will achieve our national security goals. Total force management policy dictates that military personnel be used only for positions that "require military incumbents for reasons of law, training, security, discipline, rotation, or combat readiness" We use civil servants for those civilian activities that are governmental or essential to mobilization. Comparative costs then determine whether the remaining civilian jobs are assigned to in-house or contractor personnel. In addition, we rely upon and actively promote host-nation support.

Where missions do require U.S. military personnel, both cost and responsiveness capabilities are considered in determining whether the

missions should be assigned to the reserve or active components. Major considerations in assessing the capability of reserve units to perform specific missions include availability, the possible need for forward deployment in peacetime, and peacetime work loads. The continued success of the total force policy in a period of fiscal constraint also requires that those units in the total force that will be the first to fight--whether they are active units or reserve units--get priority in resource allocation.

The Department also has in place plans and strategies to improve the productivity of the total force. These include the implementation of total quality management and the use of labor-saving capital investments, efficiency reviews, quality circles, and commercial activity cost comparison studies. Our goal is to seek continuous reductions in cost, while at the same time improving the quality of support provided the U.S. Service member.

II. Requirements

End Strengths

The following table shows the President's budget request for FYs 1990-1991, as originally submitted and as amended, along with end strength numbers for FYs 1988 and 1989.

	<u>FY 88</u> (Actual)	<u>FY 89</u> (Auth.)	<u>FY 90</u> (Original)	<u>FY 90</u> (Revised)	<u>FY 91</u> (Original)	<u>FY 91</u> (Revised)
Act Mil	2,138,200	2,133,200	2,138,200	2,121,500	2,134,600	2,120,100
Sel Res	1,158,400	1,170,700	1,178,300	1,178,200	1,181,700	1,182,200
Civ*	1,090,200	1,108,800	1,104,200	1,103,600	1,101,100	1,100,300

*Direct and Indirect Hire

For active duty military, FY 1990 total end strength is reduced 11,668 from the programmed FY 1989 position and by 16,700 from the original FY 1990 budget. The Army reduction of 7,400 from the FY 1989 position takes out a brigade of the 4th Infantry Division, reduces INF forces in Europe, and reduces accessions and students to match the lower end strength. The Air Force reductions in FY 1990 occur as a result of bomber and fighter reductions and some contract actions. The Navy reduction encompasses, among other initiatives, a reduction in the number of aircraft carrier battle groups from 15 to 14, a transfer of 4 frigates to the naval reserves, the decommissioning of 11 destroyers, and an increase in the number of Navy SEAL platoons and Navy health care personnel. In addition, the Navy foregoes a planned increase of 4,400 in FY 1990 active duty end strength.

For FY 1991, the total active military end strength is reduced by another 1,400 spaces from FY 1990. The Army reduction (~300) is due to the reduction in size of Apache helicopter units. The Air Force reduction (1,100) is tied, among other initiatives, to the removal of the GLCM weapon system in Europe. The Navy does not

change end strength between FY 1990 and FY 1991, but it does decommission another 11 destroyers and transfer 6 more frigates to the reserves; these actions are offset by further increases in SEALS and by naval growth.

The Selected Reserve increases by 7,500 from the programmed FY 1989 position in FY 1990 and grows by an additional 4,000 in FY 1991. These increases are necessitated by the expanded scope, size, and nature of missions assigned to the Reserve Components that require units of the Selected Reserve, especially early-deploying units, to be manned at levels that make them ready for combat on short notice.

The Department's civilian work force estimates reflect a requirement for approximately 1,104,200 direct and indirect hire end strengths in FY 1990 and 1,100,300 in FY 1991. Our FY 1990 civilian manpower estimate represents a reduction of about 5,200 spaces from the FY 1989 estimate, and the FY 1991 estimate is reduced by an additional 3,300 spaces. These adjustments reflect many small adjustments (both increases and decreases) in funded workloads and mission requirements, most notably a 7,954 space reduction in anticipation of work force savings from successful future Commercial Activities studies.

Oversight of Requirements Determination Process

During development of the FYs 1990-1991 Budget and the FYs 1990-1994 Five Year Defense Program, DoD analyzed the proposed changes in manpower plans. The budget information in the Defense Manpower Requirements Report provides the foundation for further analysis of the Services' manpower programs, distribution plans, and personnel inventories. Our ongoing oversight efforts continue to identify potential problems, audit compliance with Secretarial guidance and Congressional direction, and allow aggressive managerial involvement to improve stewardship of the Department's manpower resources. This will ensure a better match of mission and work load to resources and manpower, which is the goal of an effective requirements process.

In our effort to expand manpower oversight we have also begun regular assessments of the Services' billet-level manpower files. The project required assembling computer systems and building a large-scale manpower data base at the Defense Manpower Data Center in Monterey, California. This is a long-term initiative that will, in time, allow OSD to track and analyze Service manpower requirements and distribution plans. The potential exists, for example, to tackle large-scale analytical reviews of enlisted manpower requirements by occupation and grade--a level of specificity heretofore not achievable. As the information systems mature, our management of the dynamics of enlisted force supply and demand management will improve.

Concurrent with OSD initiatives to improve the oversight of requirements determination processes and results, the Services are enhancing their requirements determination methods by integrating

them into the efficiency review process. That process, which requires the user to review and improve existing procedures for establishing requirements before labor standards are set, has the potential to reduce manpower costs significantly.

Total Force Manpower Requirements. To support its manpower budget request, the Department continues to improve the oversight process for DoD total force manpower requirements. We have drafted a new directive on total force management that more clearly states DoD policy and assigns responsibilities among DoD organizations; and we continue to develop better tools for determining, managing, evaluating, and overseeing the force mix. Contract research is assisting us in areas such as measurement of manpower costs and the development and utilization of data bases to evaluate the force mix. Implementation of the proposed policy is a long-term effort involving a wide range of DoD leaders, and we are making considerable progress.

Officer Reductions/Validation of Officer Requirements. As a result of the Department's inability to justify officer growth between FYs 1980 and 1986, the FY 1987 DoD Authorization Act directed 1 percent, 2 percent, and 3 percent active duty commissioned strength reductions for FYs 1987, 1988, and 1989. The FY 1988 Authorization Act rephased the reduction to 1 percent in FY 1988, 2 percent in FY 1989, and 2 percent in FY 1990.

After DoD absorbed the FYs 1987 and 1988 officer cuts, we completed an exhaustive officer requirements study, and Congress removed the remaining reductions. We have now established more efficient controls over officer growth by requiring all significant changes in authorized manpower levels to be validated prior to implementation. We also have underway a review of field grade officer strengths that will begin with a look at O-6 positions during calendar year 1989.

The previous officer reductions have had an impact on personnel management plans, individuals, and officer communities. Furthermore, officer reductions resulting from the 1988 Defense Officer Requirements Study, the Vander Schaaf Study on manning of Unified and Specified Commands, and the DoD FYs 1990-1991 revised budget are continuing through FY 1991. Altogether, DoD will have reduced over 10,600 officer billets by FY 1991 from the FY 1986 baseline.

General and Flag Officer Requirements. In 1988, the Department completed a comprehensive study to validate General and Flag Officer (GFO) requirements. This validation process was conducted by each Service and the Joint Staff using a common methodology developed by an independent contractor, the Hay Group. The study validated requirements for 1,436 GFOs. The Deputy Secretary directed the Services and JCS to implement the findings of the study by restricting assignment of officers to billets commensurate with the validated requirements. At the same time, he directed an annual revalidation of 25 percent of GFO requirements. The first annual revalidation is now in the final stages, and it shows every sign of supporting the requirements developed in the original study.

Manpower, Personnel, Training, and Safety in Acquisition. We have issued a DoD directive on manpower, personnel, training, and safety in the acquisition process and are monitoring the implementation of that directive and conducting analyses of Service estimates of manpower needed to field major weapons systems. Industry and the Services are making great strides in improving designs to allow for better operations, maintenance, and training. This is a high-payoff area that will remain a priority for years to come.

Unified and Specified Command Headquarters Requirements. In December 1987, the Secretary of Defense directed a review of the military and civilian manpower in the Department's Unified and Specified Command Headquarters organizations. This review, which has come to be known as the "Vander Schaaf Report," recommended specific reductions to the Unified and Specified Headquarters. The Secretary of Defense and the Chairman of the Joint Chiefs of Staff agreed to reductions of 3,000 military and civilian spaces. They further agreed to reinvest 2,244 spaces to satisfy unfilled requirements in combat and medical support operations. These actions are reflected in the FYs 1990 and 1991 budgets.

Medical Manpower Requirements. The Department recently completed a major study of wartime requirements for medical manpower and deployable medical facilities. The results indicate that programmed aggregate physician supply would be roughly in balance with requirements, but we anticipate shortages in some specialties, especially in the field of surgery. As a result of the study, we have undertaken several tasks to strengthen our basis for projecting medical manpower requirements. My office is heading Department-wide efforts related to estimating combat casualties, translating these into required hospital manpower and beds, and accounting for physicians needed outside hospital settings.

Total Force Mobilization Requirements. The ability to mobilize effectively is a key deterrent to war. Mobilization is a complex process requiring sound peacetime planning, stockpiling, and exercising for success, particularly if mobilization must be done quickly.

We continue to identify and develop human resource alternatives to our current manning structure that will enable us to use all of our total force manpower resources in wartime. This analysis includes not only the active and selected reserve force, but also the qualitative management of the Individual Ready Reserve (IRR), retired military personnel who could be recalled to duty in a crisis, and untrained personnel who would be drafted and trained. In addition, we are focusing on improving mobilization planning and preparedness for the more than 300,000 additional members of the civilian work force who will be required almost immediately upon mobilization to meet expanded wartime support requirements and to replace employees who have a military obligation.

We are also assessing the accuracy of our wartime manpower requirements estimates. In particular, as noted above, we are concentrating on the Services' casualty estimates, which drive wartime replacement demand. We are comparing casualty estimates with historical experience, field exercise results, and the estimates of our allies.

Congressional Support Needed

As we improve our requirements determination process, Congress can help us by removing several legislated personnel ceilings. Arbitrary ceilings interfere with the Department's ability to match missions and work loads with manpower and therefore reduce our ability to manage our forces in the most cost-effective way. The Department has repeatedly demonstrated the ability to manage civilians effectively without a legislatively imposed civilian ceiling; we would like a chance to translate this experience into the management of all our manpower resources.

Two troop ceilings--one for NATO Europe and one for Northeast Asia--are currently in existence. The current NATO European ceiling of 326,414 was established in 1985. Although DoD actually has programmed end strength under the ceiling for FYs 1990 and 1991, we believe that this ceiling should be removed, because DoD should be allowed to deploy force structure as needed to meet the threat. The current Northeast Asia ceiling, enacted with the FY 1989 Appropriation Act, is 94,450 and equates to the total number of permanent U.S. military members ashore in Japan and Korea as of September 30, 1987. This new ceiling does not apply to FY 1990, and the Department urges support for no such ceiling in future years. In conjunction with the imposition of troop ceilings, there has been considerable Congressional interest in reducing the number of military dependents overseas. I urge the Congress to move with extreme caution in this area. While the desire to reduce the cost of maintaining troops overseas is understandable, reducing dependents would lead to lower retention, create serious morale problems, and ultimately cost more.

The FY 1989 Appropriation Act also continued the ceiling on overseas civilian workyears and reduced the initial workyear ceiling (established at 188,496, the actual FY 1986 execution level) to 182,011 (the actual FY 1987 level). We remain opposed to legislatively imposed civilian employment controls in general, and selected geographic controls in particular. The civilian work force is a resource that can best be managed on mission requirements and funded work load. The overseas workyear ceiling also impedes our ability to hire spouses who accompany Service members to locations outside the continental United States.

Another civilian ceiling that hinders our ability to manage effectively is the ceiling on Defense Agency and Field Activity personnel mandated by Title VI of the DoD Reorganization Act. We ask for your support in lifting this and the other restrictive ceilings I have mentioned.

III. Recruiting

Military Recruiting

Since 1986, we have managed to sustain high levels of military recruit quality despite significant reductions in the real dollar value of available recruiting resources. Productivity enhancements increased the average manyears per accession and will pay further dividends in reduced accession requirements in FY 1991. Further reductions in accession levels resulted from last year's force structure drawdown. Together these factors more than offset any potential reduction in recruit quality that might have been produced by a slightly smaller pool of quality applicants.

Our recruiting results from the first half of FY 1989 show that, while not quite reaching the historic highs achieved in recent years, the Military Services are exceeding or meeting their objectives. Although the Army technically met its recruiting goals, it did so by shifting several thousand accessions originally planned for the first half into the last six months. Eighty-nine percent of new Army recruits were high school graduates, and 89 percent scored average or above on the enlistment test. The proportion of recruits scoring in the lowest acceptable test category grew to 11 percent (compared to 4 percent a year earlier). This exceeds the maximum desired level established by the Army in the 1985 Report to the Congress on Defense Manpower Quality by 1 percentage point, but remains 19 percentage points below the proportion of American youths with similar scores. For all Services, 90 percent of new recruits were high school graduates, and 92 percent tested average or above.

A more serious concern is the continuing decline in the proportion of recruits who sign enlistment contracts up to a year in advance. At the end of the first half of FY 1989, 42 percent of the FY 1989 objective had been recruited, versus 49 percent in FY 1988. In order to reverse this trend and to preserve the continued successes in recruiting, we need your strong support for all the recruiting resources and tools that we have.

Recruitment Tools

In view of the declining youth population and strong employment outlook, we need to act now to reverse negative recruiting trends before serious problems develop. We need the support of the Congress for the recruiting initiatives contained in the FYs 1990-1991 revised budget. These include funds for (1) Army and Navy supplemental educational benefits to increase the average term of quality enlistments, (2) Joint and Service-specific advertising to inform young people and influencers of military service opportunities, (3) placement of recruiting facilities where the youth market is growing (while closing those where it is shrinking), and (4) adjustment of recruiting incentive ceilings to counteract the effects of inflation

since they were originally established. In addition, we must protect the 3.6 percent pay raise.

A recent RAND study documents the cost-effectiveness of both Service and Joint advertising programs in generating additional quality enlistments. The study suggests that advertising is about as effective as adding recruiters to stimulate quality applications, and both are twice as effective as enlistment bonuses at expanding the recruiting market. Bonuses, on the other hand, are most effective at channeling recruits to hard-to-fill skills. The study concludes that a flexible mix of each of these resources is needed in order to respond effectively to rapidly changing market conditions. A copy of the RAND analysis is included in a recent report on Joint and Service-specific advertising we provided to the Congress.

The imposition by the Congress of restrictive advertising ceilings and fund reallocation constraints has hampered our ability to respond effectively to recent recruiting difficulties, and we look forward to working with this subcommittee to forge responsible yet responsive controls that permit us to manage recruiting activities as well as the state of the art permits.

The Montgomery GI Bill to provide post-high school educational benefits has now been in place for over three years, and Service members like it. Participation rates have steadily increased since the program's inception. The Army has almost an 84 percent participation rate, while the Department as a whole has about a 69 percent overall rate, through April. These participation rates are expected to increase as a result of the open period for eligible participants who initially declined enrollment. While many factors influence Service recruiting, it is clear that the Montgomery GI Bill is popular and has been effective in increasing the quality of the active components and the length of enlistment contracts for the reserve components.

Congressional Support Needed

Despite 15 years of success with the volunteer force, proposals abound to reinstitute the draft or develop a national military service program. Most are based on beliefs that alternative programs, when compared to today's volunteer force, would be cheaper, improve social representation of the force, produce a higher quality force, help meet military manpower requirements, or develop a sense of community obligation among youth. While few would argue against the goal of increasing the number of Americans who recognize their responsibilities as citizens by pursuing constructive ways to serve their country, there is no evidence of any improvement in the other areas of alleged problems.

We can all agree that our goal should be to sustain a force of the same quality and experience that we have today. Even though the costs vary depending on which alternative to the All-Volunteer Force is considered, every analysis shows that to sustain a force of the same quality and experience, conscription or national military

service would be more costly than the current all volunteer system. Many of the national service proposals before the Congress would destroy the effectiveness of current programs designed to attract and distribute quality enlistments. By establishing lucrative alternatives for civilian service or shorter enlistments, they would reduce recruit quality, increase training costs, and adversely affect the productivity of military personnel. By providing increased levels of individual benefits, they would cause the number of assisted college students to decrease substantially or the cost of educational programs to increase substantially. Minority participation in the force would probably increase, not decrease, and federal budget costs would increase without increasing active or reserve accessions. Some of the proposals raise constitutional concerns that are being reviewed by the Department of Justice.

The Administration will forward to Congress, probably by early summer, its own youth service bill. That proposal was described by the Secretary of Energy, Admiral Watkins, on April 21, 1989, before the Senate Committee on Labor and Human Resources. The President's proposal will call for voluntary national service programs that are integrated into a young person's normal schedule and career path (as opposed to programs that require a set period of full-time service) and will not attempt to compensate young people for service with Federal dollars, out of the belief that service itself would be its own reward.

Because the volunteer force has proven to be highly effective, and because we have clearly demonstrated the ability to attract the number and quality of people we will need during the next decade, there is no need for either a peacetime draft or national service to satisfy military manpower requirements. There is, rather, a strong need to sustain our success by restoring the value of resources and incentives for recruiting and retention, maintaining the purchasing power and competitive appeal of military compensation, and sustaining political support for our armed forces. We request your support in doing this. We cannot afford to bid up the price for military manpower by setting up competitive forms of service that provide financial compensation, particularly during a period of high employment and a shrinking youth population.

Civilian Recruiting

In the past few years, a number of studies have been conducted, some internal to Defense, and more recently, government-wide, dealing with Federal civilian employment and personnel management systems. The conclusions of these studies are stated succinctly in the budget document, "Management of the United States Government, 1990," which says, "Future labor force projections indicate there will be insufficient numbers of skilled employees to fill the available jobs. This is particularly true for most of the Government's job categories . . . Confronted with the prospect of competing with the private sector for workers having necessary skill levels, Federal personnel policies and practices must also undergo significant adjustment." We are deeply concerned about the overall civil service personnel system

and our future ability to recruit and retain high-quality civilians for DoD, particularly in scientific, engineering, and technical areas.

To overcome problems in civilian recruiting, we have formed a DoD task force to examine critically our future demand for scientific, engineering, and technical manpower versus labor market availability. We will examine initiatives that will ensure that DoD can recruit, train, and advance sufficient numbers of qualified civilians to meet our emerging technical and scientific needs. We will be looking particularly at tailoring specific strategies for reaching women, minorities, and disabled persons so that we can capitalize on the talents and energies of these groups, particularly those who have specialized in research and technology career fields. The Defense Science Board has expressed its support for this undertaking and plans to participate with us in the task force review.

IV. Training

Military Training

Training of military personnel and operational units has improved markedly during the 1980s, and we have held the line on those in the revised FYs 1990-1991 budget. The improved personnel situation has raised the quality and residual value of training. The development of challenging, technologically advanced training facilities has made time spent in training more productive in terms of readiness. The maintenance of levels of operating tempo (OPTEMPO)--flying hours, steaming days, vehicle miles--has generally been adequate for carrying out essential training.

While experienced commanders are subjectively convinced that training and related readiness have improved, DoD needs to make more progress on objective measures to link training activity to readiness. As part of an all-encompassing effort to improve our ability to model the relationship between resources and capability and to develop better aggregate indicators of military capability and readiness, we have been engaged in a comprehensive research program to develop linkages between OPTEMPO and performance. The goal is to be able to provide more definitive answers to such questions as: if flying hours are increased (or decreased) by a certain percent, what is the effect on performance? This is a difficult analytical problem, but results to date indicate that performance continues to improve with OPTEMPOs beyond current average levels, thus tending to confirm that budgeted OPTEMPO levels should be seen more as the minimum rather than the optimum levels.

The FYs 1990-1991 revised budget continues to give training a high priority, even to the point of sacrificing other important programs. Most operating tempos in the President's budget are at the same levels in FYs 1990-1991 as in previous years; for example, about 25 flying hours per crew per month for Navy and Marine Corps tactical

air-antisubmarine warfare aircrews and 19 hours for Air Force tactical pilots. Army ground OPTEMPO will fall somewhat below the level programmed for FY 1989 but will be about the same as it was in FY 1987 and higher than in 1988. Ship steaming days for the Navy will also remain level.

Civilian Training

While directing the DoD implementation of an OPM-sponsored, Government-wide training program, DoD reviewed leadership training opportunities throughout the Department and noted that the military side of DoD created a greater link between career advancement and training than did the civilian sector. In comparison to the diversity of leadership training opportunities for mid-level military officers, civilian employees had little exposure to training in leadership. Additionally, although there is a trend toward greater civilianization of the DoD total force, little opportunity exists for more than a few civilians to be trained in the military schools. The review also illuminated a dearth of women in the executive ranks of the DoD civil service. To overcome these problems, we initiated in October 1985 the DoD Executive Leadership Demonstration Program (ELDP) on a trial basis. Since then, two complete cycles of the program have been completed with 132 graduates--117 civilians and 15 military--and a third is underway. This program is a unique developmental opportunity, providing broad, DoD-wide managerial perspectives not available elsewhere. After careful evaluation, we decided to establish ELDP on a permanent basis. Its focus on the joint arena complements our current efforts to develop strong, Department-wide perspectives and leadership skills.

Congressional Support Needed

We believe that training is truly the most cost-effective force multiplier. To realize the potential combat capability of our forces, it is essential that Congress continue to provide the funding required for effective training. Until and unless we can clearly demonstrate improvements in readiness from other approaches, we need to maintain the minimum OPTEMPO levels for which we have budgeted.

V. Utilization of Manpower Resources

We have devoted considerable effort in the past few years to solving problems discovered in use of certain of our manpower resources: women, joint officers, and civilians.

DoD Task Force on Women in the Military. The Secretary of Defense has received negative reports from the Defense Advisory Committee on Women in the Services (DACOWITS) concerning the treatment of some of our women at various overseas locations that DACOWITS has visited during the past two years. As a result of the 1987 DACOWITS report, the Secretary established a special task force

and charged it with looking into attitudes toward women in the military, career development, and the application by each Service of the law excluding women from combat.

During 1988, the Department implemented many recommendations of the DoD Task Force on Women in the Military, and we remain committed to expanded and enhanced career opportunities and career development for women. In keeping with the policy that women are to be used in all roles except those explicitly prohibited by law, and interpreting the law to allow as many career opportunities as possible to be kept open, the Department adopted a new "risk rule" to help assess which positions should be open and which should be closed. Using the risk rule, the Military Departments reviewed positions closed to women and opened more than 24,000 additional positions. Additionally, the Department implemented Task Force recommendations on the elimination of sexual harassment through aggressive leadership initiatives, improved education and training, and responsive complaint systems. We are conducting a survey on sexual harassment and will use the results to guide our continuing efforts to prevent such harassment.

Joint Officer Management. Title IV of the DoD Reorganization Act of 1986 imposed stringent requirements on DoD concerning management of officers in joint organizations. We continue to make progress in improving the education, training, and experience of joint officers, but we also continue to encounter personnel management obstacles in Title IV implementation.

Our actions in implementing the provision of the Goldwater/Nichols Reorganization Act relating to joint management have included publishing a number of policy memorandums pending issuance of DoD directives, publishing an updated Joint Duty Assignment List, implementing a new joint assignment management information system, and conducting an extensive review and modification of the joint education system. The FY 1989 DoD Authorization Act contained important amendments to the joint officer management provisions of the Goldwater-Nichols Act that have significantly enhanced the Department's ability to implement those provisions. Reduced tour lengths, grandfathering provisions, and the extended transition period have been particularly helpful.

Flexible Alternatives to the Federal Civilian Personnel System.

In 1986, the Packard Commission expressed concern over the problems they found in our recruiting and retention of civilians and in our ability to provide incentives for high-quality scientific, engineering, and acquisition personnel. The China Lake Demonstration Project on pay banding, started in 1980, had earlier paved the way in our efforts to work with the Congress on personnel system reform.

We remain deeply concerned that the current civil service personnel system may prove inadequate to the recruiting and retention of high-quality professional and technical civilians. We are convinced that there must be a more efficient and flexible way to determine how jobs are valued and how individuals are paid. We strongly supported the OPM-sponsored Alternative Personnel Management

System legislation in 1987. Last year, we sought expanded authority to test alternative employment and compensation systems in Defense and NASA. Neither of these initiatives have been passed, but the ongoing Defense Management Review will recommend several steps to the President.

VI. Retention

Officer and Enlisted Retention

Overall, the Department has continued to be successful in retaining a high-quality officer and enlisted force. However, projected officer shortages of pilots, nuclear officers, and medical personnel as well as in certain mission-critical enlisted personnel will require continued attention. The officer retention issues are addressed under specialty categories separately, but let me make a general observation about enlisted retention.

Overall enlisted retention rates remain satisfactory but most are now several percentage points below the FYs 1982-1984 peaks. Losses among high-demand or arduous skill specialties call for judicious application of scarce incentive bonus resources, and sustaining compensation and quality of life incentives will be essential to forestall continuation of recent downward trends.

As we enter a period of stiffer competition with the private sector for a smaller population of candidates, we must be especially sensitive to retention. Maintenance of incentive programs will be vital to the proper mix of officer and enlisted experience and skills.

We need to maintain the purchasing power and competitive appeal of military compensation and do all we can to ensure quality of life for our personnel. Our efforts to do so are detailed below.

Retention Tools/Military Compensation

Competitive compensation is the central ingredient in the Department's ability to attract and retain the people we need. For the current fiscal year, we did well in the compensation area. We deeply appreciate this subcommittee's continued support for the pay raise in FY 1989. The challenge for us in FY 1990 and beyond is to maintain our competitive position in tight budget and employment environments.

Military Pay Raise. In FY 1989, for the first time in seven years, military members received a pay raise greater than wage growth in the private sector. The military raise of 4.3 percent exceeded the 3.5 percent raise in the private sector, as measured by the Employment Cost Index (ECI), and reduced the difference between private sector pay increases and military pay increases that had

occurred since FY 1982. Nevertheless, there is still a considerable pay gap of 10.1 percent.

The Department is requesting a 3.6 percent military pay raise in FY 1990. This increase is less than we would have preferred. We had originally planned for a 4.6 percent raise, which would have slightly exceeded projected private sector wage growth of 4.3 percent and reduced the gap even further. However, because of budget considerations, we have had to reduce our request to 3.6 percent. Combined with the lowest unemployment rate in 14 years, this action increases the risk that the healthy recruiting and retention experience of the past several years may deteriorate.

Bonuses. The enlistment and selective reenlistment bonus programs are two of the most effective tools we have available to the Department in meeting recruiting and retention requirements. They are particularly important in helping us fill high-skill, mission-critical specialties. They also provide important flexibility to retarget resources quickly to accommodate changing forces in the manpower marketplace.

Enlistment bonuses have proven to be highly effective incentives for attracting top-quality enlistees to the skills in which they are most needed. They are paid only to high school graduates who test in the upper half of their peer group and who agree to serve at least one year beyond the normal enlistment period. The bonus is paid only after completion of initial skill training.

Selective reenlistment bonuses are paid to members who reenlist or extend for at least three years in designated critical skills. These bonuses enable the Services to protect their extensive training investments in highly skilled and experienced personnel, and to avoid the substantial accession, training, and readiness costs associated with replacement of seasoned professionals with new recruits. When annual pay raises lag behind private sector comparability levels, as they have in several recent years, the reenlistment bonus program becomes doubly important for enabling the Services to sustain adequate retention levels in the skills most important to the accomplishment of their missions.

As important as these programs are, they have not been exempted from the constraints of fiscal reality. Bonus expenditures for FY 1988 were below those for FY 1987 and considerably below those of FY 1986, and this program will continue at relatively austere levels in FYs 1989 and 1990. While both the Congress and the Department have exercised difficult judgments in reducing bonus funding, it is important that we candidly acknowledge the very real risks entailed. Bonus programs are our safety net to protect against manpower shortfalls in our most important skills. Any reductions beyond those now programmed may increase these substantial risks by limiting our ability to maintain mission-critical skills and to react in the event of a retention downturn. We ask for your strong support of these cost-effective programs.

Monetary incentives will be particularly important in retaining aviators. Airline hires have reached record levels, and military-experienced pilots constitute about half of the airline hires. They are preferred by the industry because of their professional attributes, especially their experience in heavy fixed wing aircraft. During the next decade, hiring levels are expected to be nearly three times what they were in the 1970s. The strong inverse relationship between airline hiring and retention and the increasing hiring tempo within the industry signal a growing problem in aviator retention. The problem will be especially pronounced in the Air Force and the Navy, because of their substantial numbers of fixed wing pilots completing initial obligations each year.

It is difficult to offset unanticipated pilot shortfalls with more training because training is both expensive (jet pilots take about two years to train at \$1 million each) and constrained by available training equipment. This creates an even more compelling demand for retaining those aviators now serving. By the end of this fiscal year, we project that the Navy will be short about 1,500 pilots. The Air Force is also short several hundred. The problem will grow more severe each year--more rapidly in the Air Force--as the better earning opportunities offered by the airlines continue to take their toll in retention.

The shortage of experienced nuclear-trained officers in the grades of lieutenant through captain continues to be a critical manning problem in Navy. For FY 1990, the Navy projects an inventory shortfall of 28 percent compared to requirements for officers in these grades. One of the initiatives undertaken to address this shortfall has been an increase in the Continuation Pay, or COPAY, provision of the Nuclear Officer Incentive Pay program enacted in FY 1986. Current statute authorizes COPAY payments of up to \$12,000 per year for officers remaining on active duty for three, four, or five years after completion of their initial obligation. Initially, the Navy employed a COPAY rate of \$9,000 per year but raised the rate to \$10,000 in FY 1988. This action, in conjunction with a 35 percent increase in submarine pay provided in the FY 1988 Authorization Act, has helped increase the retention rate among submarine officers from 39 percent in FY 1987 to 45 percent in FY 1988.

The long-term nature of the nuclear-trained officer shortage continue to require the temporary spot promotion of some exceptional lieutenants to fill certain essential lieutenant commander engineering billets. This program is a no-cost management tool that is used only when needed. All promotions occur within statutory grade ceilings. Authority for this important program expires on September 30, 1989, and the Department is seeking your support for legislation to make permanent this spot promotion authority as part of the FYs 1990/1991 Authorization Bill.

Health care professionals, particularly physicians, are among the highest paid professionals in both civilian life and military service. Nonetheless, shortages remain in certain specialties, especially surgical, where the compensation we offer lags most behind

compensation found in the economy. Most of these surgical specialties are part of the wartime critical list; we remain relatively better off in peacetime specialties devoted to family, pediatric, and geriatric care. The Congress foresaw this growing problem and authorized for FY 1989 a temporary, one-time bonus of up to \$20,000 per year for a multi-year extension of up to four years. The Department has sent the Congress a report detailing how this bonus would be administered. In addition, the Department submitted a report that addressed the long-term compensation problem, and is preparing additional data requested by the Congress. The draft legislation contained in that report is now being staffed within the Executive Branch.

Allowances. After two years of budget constraint, we appreciate the funding increase approved by Congress for the Variable Housing Allowance (VHA) program in FY 1989. As intended under the law, this increased funding enabled us to provide VHA rate increases in those areas where members are experiencing the greatest housing cost growth. However, a funding ceiling was again imposed on the VHA program in FY 1989. The ultimate cost of VHA in any particular year is determined by the average number of VHA recipients over the entire fiscal year, by grade and dependency status, in each of the over 350 different military housing areas. Because we cannot estimate each of these factors with pinpoint accuracy, complying with a funding ceiling means we must take one of two undesirable approaches in setting the rates: we either build in a large safety factor to ensure that we do not exceed the ceiling, or we set rates based on our best estimate and run the risk of having to reduce the rates later. We understand the desire to control VHA program costs, but this is already accomplished by a provision in law that prevents VHA rates from increasing in any year by more than housing cost growth in the Consumer Price Index. For FY 1990, we are asking for a 3.6 percent rate increase, and we are hopeful that Congress will not impose a ceiling. !

The Overseas Housing Allowance program is operating well. This allowance, along with the Cost of Living Allowance, is being adjusted, as needed, for cost changes and currency fluctuation. The problem in the overseas allowances program, which has existed for some time, is a funding shortfall created because the Foreign Currency Fluctuations account cannot be used for Military Personnel costs. The Congress has continued to deny our request to use this account for this purpose.

We appreciate Congressional approval of the increase in household goods weight allowances. This increase will reduce the out-of-pocket expenses many members incur when making a permanent change of station move. We are conducting a survey to collect data on expenses members incur when moving. The results of this survey will enable us to identify areas where additional improvement is needed.

Retention Tools/Quality of Life

In addition to its commitment to adequate compensation and benefit levels, the Department is fully committed to supporting initiatives that contribute to the well-being of DoD personnel and their families. Initiatives in this area include morale, welfare, and recreation programs; family support services; and dependent education.

Morale, Welfare, and Recreation. The DoD Morale, Welfare, and Recreation (MWR) program is a major contributor to community life on military installations. Libraries; sports and athletic programs; military exchanges; open messes (clubs); child care and youth activities; theater; crafts; and a wide variety of other social, resale, recreational, and developmental activities serve approximately 12 million patrons and participants. They generate over \$10 billion in sales, employ 220,000 people, and account for about \$4.2 billion in program cost, exclusive of cost of goods sold. Over \$3 billion is funded by nonappropriated funds; the remainder is provided through appropriated fund support.

For the past three years, the Congress has directed cuts in appropriated fund support; and for FY 1989, the Congress enacted a statutory ceiling of \$1.163 billion. These cuts have been targeted at revenue-producing activities--clubs, bowling centers, golf courses, marinas, etc.--that might be operated largely with patron fees. The Congress will permit greater appropriated fund support for these activities only if they are located on installations designated as remote or isolated. My office sent a list of remote or isolated bases to the Congress for its review. We have received the Congressionally approved list, and we are providing guidance to the Services and changing the appropriate directives. All DoD components have taken measures to operate MWR programs within legislative caps and to make revenue-generating activities more reliant on their own incomes, derived from patron fees and charges.

Family Support. On December 30, Deputy Secretary Taft signed the first Department directive on family policy. This document directs the Military Departments to establish comprehensive family support systems and emphasizes the importance of collaboration and coordination to maximize the use of scarce resources.

One of our greatest family support challenges is to meet the needs of our personnel for quality child care at affordable prices. With our increased numbers of dual career and single military parents, it is essential that we ensure that child care is available. This is an important readiness issue. We estimate that we currently accommodate 129,000 children in either family home or center-based child care and that we have a need for 81,000 additional spaces for children of military parents alone. We need your continued support for child care center construction to replace inadequate, unsafe facilities and to build new ones to help meet our substantial need. The Department will continue to encourage home day care programs and

will pursue other initiatives such as private financing and GSA leasing of space to meet our military child care needs. We also are concerned about the quality and safety of our child care programs, and we are issuing a DoD instruction that establishes standards for child care being provided in DoD activities.

In other family support areas, we also have implemented a test program for reimbursement of adoption expenses. We have continued to improve our support to Service family advocacy programs and have established a DoD Family Advocacy Command Assistance Team that will support installation efforts to resolve alleged instances of child sexual abuse occurring in DoD-sanctioned activities. Finally, we will complete the evaluation of the Congressionally directed contract relocation assistance test this summer and use the results of this evaluation to formulate policy recommendations that will shape relocation policies and management of relocation assistance by the Services.

Military Spousal Preference. Section 806 of the Department of Defense Authorization Act of 1986 recognized that reasonable employment opportunities for military spouses enhanced the well-being of the military family and contributed to maintaining a healthy military family life style. It provided for employment preference for best qualified military spouses for a wide range of both appropriated and nonappropriated fund DoD positions throughout the world. Since implementation of the spousal hire preferences in 1986, the Department has continued to refine and expand its policies to enhance spousal employment. In January of 1989, DoD published a consolidated and revised spouse preference policy, and the program now provides for the use of the DoD Priority Placement Program for spouse registration and referral for many appropriated fund positions in the U.S.

We are extremely proud of our efforts to date. Since 1986, we have placed over 27,000 military spouses into a variety of appropriated and nonappropriated fund jobs under the preference program. All told, there are over 60,000 military spouses working in civil service jobs for the Department of Defense. We will continue to review and refine the program in an effort to provide maximum assistance to our military spouses and their families, while ensuring that our civilian workforce quality is maintained.

Department of Defense Dependents Schools. Over the past eight years the student population in our overseas schools has grown dramatically (from under 130,000 to more than 155,000, or nearly 20 percent). This growth has called for both flexibility and responsiveness on the part of all charged with responsibility for these schools.

Our major priority for DoDDS has been to improve communication among parents, school officials, and commanders. DoDDS has implemented a major initiative to improve communication throughout the DoDDS system.

We are proud of the quality education our dependents receive. DoDDS students' scores on tests in basic skills such as reading, language arts, mathematics, science, and social studies have been above the national norm for the past five years. In addition, DoDDS students have consistently performed at or above the national average on college entrance examinations for the past ten years, and their scores have compared favorably with scores in states that have tested comparable percentages (50 percent) of students.

Congressional Support Needed

We need your support in preserving the compensation and quality of life programs detailed above. They are vital to retaining the kind of people we need to carry out our mission successfully.

VII. Conclusion

Mr. Chairman, we have made great strides in the manpower area in the last seven years, and this subcommittee has been instrumental in the improvements made in personnel quality and readiness. In this year of reduced budgets, the manpower and personnel concerns of the Defense Department will be particularly vulnerable and will present great challenges both to the Department and to the Congress. I ask for your help in ensuring that the significant progress that has been made not be undone. Our continued success depends on your support for adequate recruiting resources and incentives, compensation, and quality of life for our Defense family.

We have devoted a great deal of attention to improving our ability to determine the appropriate mix of personnel and to validate our requirements for these personnel. We pledge to continue to concentrate on these efforts, so that, with your support, we can strengthen our ability to manage this most critical of all our defense resources.

MANAGEMENT REVIEW

Senator INOUE. The budget projects savings of about \$286 million from the management review. Are we likely to abolish the Air Force Systems Command or the Army Materiel Command?

Mr. BERTEAU. Let me back up a little bit on the status of the review. Of course it was directed by the President in February when he appeared before the Congress with his revised budget statement, with the aim of fully implementing the Packard Commission recommendations. That review is still in the final stages of preparation and has not been delivered to the President for his approval, although such a delivery I believe is imminent.

It will attempt to encourage and commit to some organizational and structural changes within the military departments in order to bring about the Packard Commission changes, particularly of a streamlined acquisition decision process so that there are fewer layers between the program manager and the acquisition executives.

I do not believe it will specify specific organizational changes within each military department. There will be some flexibility retained as to how the military departments go about doing that. There is a clear implication, however, that the status quo is not satisfactory in terms of meeting either the Packard Commission's objectives or the President's objectives.

Senator INOUE. The fiscal year 1990 Army budget has 404,000 civilians to support 765,000 military. That is a ratio of 1 for every 1.9. The Army budget proposes to eliminate 7,900 military but only 645 civilians. How come the proportion does not work there?

MANPOWER REDUCTIONS

Mr. BERTEAU. The ratio, of course, is not a firm and fixed ratio. What we try to do is look at the most cost-effective reductions—in other words, the places where we can save the most money when we are making reductions, with the least impact on our capability and our readiness.

The particular mix that came out of this budget has the proportions that you noted. A significantly greater percentage of those reductions occur in the active duty military than in the civilians.

That is not a conscious decision. We do not set about to say OK, let us reduce x percentage of military and y percentage of civilians. It is a result of the actual decisions that were made. The places where we took the military end strength reductions are not places where there is a lot of civilian support. They were combat forces both in Europe as a result of the INF Treaty and the brigade in Colorado at the 4th Infantry Division.

There is not a lot of civilian support associated with those. If there were other reductions in other areas that would have a commensurate proportion of civilian support, you would see that coming out of it. But basically it depends on what workload and missions are being changed and in this case the missions that were being taken out, the functions that were being taken out, had a much higher proportion of military associated with them than they did civilians.

Senator INOUE. You mentioned the Vander Schaaf report. Last December the Secretary of Defense submitted to the Congress his evaluation, the Department's evaluation of the Vander Schaaf report, and at that time he said that 7,309 spaces were identified in the report as unnecessary and that 3,000 could be reduced without seriously damaging the national command structure.

Did the Department eliminate these positions?

Mr. BERTEAU. The 3,000?

Senator INOUE. I gather it did not because you reinstated 2,400, did you not?

Mr. BERTEAU. But if you look at it from a billet perspective, the actual billets, the 3,000 billets were all eliminated. They are gone from the force structure, and we have got the specific billet-by-billet detail of that from each military department and from the unified and specified command headquarters.

All of those billets went away. All the jobs went away. All the people are going away. This is phased, by the way, over 1989, 1990, and 1991, so not all of them will be off the books until 1991.

The 2,244 billets that we added back are different billets in different units and in fact in many cases will be different people. What we did is, we looked through the services proposals of where to add back and we had very specific evaluation criteria. The add-back billets had to be in existing combat units where the billet was unfilled, where because of the manpower constraints that we have we literally could not fill that unit up to 100 percent of its manning.

Or, for civilians, we allowed an add-back in medical support functions where we have had some critical shortfalls in terms of the civilians that we needed.

In addition, after the Department began to wrestle with how it was going to implement its expanded responsibilities in drug interdiction and detection and the dissemination of that information to domestic law enforcement agencies, there were a couple of hundred billets that were agreed to come out of that 2,244 to support the expanded drug interdiction and detection arena, in terms of support for local law enforcement agencies.

All those billets where we added back were existing requirements that were unfilled, and we went through those billet by billet at the OSD level and validated that—and there were some which did not make it through that test. There were some proposals by the services which we did not endorse and the add-backs were not approved.

The 3,000 that were drawn down are gone. They are off the books.

Senator INOUE. I gather that there is a critical shortage in the medical operations. Of that 2,244, how many were reinvested in the medical operations of DOD?

Mr. BERTEAU. I do not have that off the top of my head. I will have to get you that for the record. I believe it is around 600 or 700, but I will have to get you that for the record, if I may.

[The information follows:]

CIVILIANS REINVESTED INTO MEDICAL OPERATIONS

It is estimated that 939 civilian spaces were reinvested in support of medical operations as a result of savings achieved by implementing the Vander Schaaf Report recommendations.

POPULATION REPRESENTATION

Senator INOUE. I have many other questions, but I would like to ask one that may involve some policy. As a personnel expert, do you believe that military personnel, men and women in uniform, should represent all segments of our society—the rich, the poor, all ethnic groups—in a proportionate manner?

Mr. BERTEAU. Not only do I personally believe that, sir; I think we have a substantial amount of evidence that in fact the All-Volunteer Force does as good a job of being a representative force as any other system we have ever had.

Senator INOUE. Are you serious about that?

Mr. BERTEAU. Yes, sir; now I cannot go back to World War II or the mid-1950's or even the height of the Vietnam war and create data because there are no data that exist that would demonstrate that.

Senator INOUE. How many college grads are we recruiting? I am not talking about those who get in to get a scholarship to become a medical doctor. But how many college grads are volunteering?

Mr. BERTEAU. I do not have the figures on that.

Senator INOUE. More than 1 percent?

Mr. BERTEAU. Oh, I think substantially more; yes, sir.

Senator INOUE. What is the number of category IV's at the present time?

Mr. BERTEAU. In the Army at the present time it is running around 10 or 11 percent in terms of new accessions. The percent that is in the service today is considerably less than that, down around 4 percent.

Senator INOUE. I would like to get the numbers on the number of category IV—I mean college graduates.

Mr. BERTEAU. I will look into that and give you that for the record. I do not have that information.

[The information follows:]

COLLEGE GRADUATE REPRESENTATION IN THE MILITARY

The Military Services require all candidates for commissioning programs to possess a 4-year college degree; thus, 100 percent of our officers are college graduates compared to 22.4 percent of the general population between the ages of 25 and 29. Of the 24,761 officers who entered the military in fiscal year 1988, 21,000 were in career fields other than medical. For enlisted recruits, 1.6 percent (approximately 4,200) had a college degree. Combining officer and enlisted accessions, approximately 29,000 (10 percent) of the 297,400 individuals entering the military in fiscal year 1988 were college graduates.

Senator INOUE. You are saying that it reflects the proportion in the United States?

Mr. BERTEAU. College graduates I cannot say that it reflects the proportion in the United States; clearly it does not.

What I am talking about is if you look at the socioeconomic and the ethnic proportions and the high school graduate proportions of the society as a whole in the age group from which we draw acces-

sions and you look at the military proportion of that, we are at least as representative as a society as a whole in terms of high school diploma graduates, in terms of the people above the 50th percentile in terms of mental capability, and in terms of the socioeconomic representation.

Clearly, 50 percent of the society are women, and 50 percent of our accessions are not women, although the percentage has been growing dramatically and is substantially higher than it ever was in any draft era.

Senator INOUE. Can you also provide in this breakdown ethnic breakdown—blacks, Hispanics?

Mr. BERTEAU. To the extent we have that broken down, yes, sir; I will provide that.

[The information follows:]

POPULATION REPRESENTATION OF MILITARY RECRUITS

Representation of the U.S. population within the Military Services has been an issue of concern for more than two decades. Discussion has focused primarily on representation as it affects military effectiveness and social equity. Comparisons of military personnel with the U.S. population have involved geographic distribution, educational attainment, test scores, gender, race/ethnicity, and various other demographic factors. Each year, the Office of the Secretary of Defense submits a report to Congress on the population representation of individuals in the military's active duty enlisted force. A copy of the report is attached.

[CLERK'S NOTE.—Due to the size, the document will be retained in the subcommittee files.]

COLLEGE GRADUATE REPRESENTATION IN THE MILITARY

Of the 24,761 officers who entered the military in fiscal year 1988 (all of whom had college degrees), 85 percent were white, 6.6 percent were black, 1.7 percent were Hispanic, and 6.6 were other. Of the approximately 4,200 enlistees with college degrees, 69 percent were white, 21 percent were black, and 10 percent were Hispanic/other.

VARIABLE HOUSING ALLOWANCE

Senator INOUE. Senator Stevens.

Senator STEVENS. Mr. Chairman, thank you.

At the time that the Department did away with the rent-plus concept some of us warned that when the situation developed that we had declining values of homes that were under long-term lease or purchase contract that VHA would be very unfair.

Now, I understand that this year there was a \$77 million surplus in VHA and rather than being variable what the Department did was to just simply divide it between the eligible military people who were receiving VHA on the basis of rank, so that each eligible person received between \$2.68 and \$15.68 per month based on rank, notwithstanding the fact that a substantial number of people had their VHA payments reduced although they were still in the same homes, living in the same communities, but the values of homes surrounding them had declined.

Their obligations were the same. As a matter of fact, they were worse because they were paying for homes that were no longer worth what they paid for them when they bought them or when they entered into long-term lease arrangements.

That is particularly true in the southwest. As a matter of fact, if you want to trace the oil country, it is in the oil country. And vari-

able is not variable at all. It calculated stupidity as far as I am concerned.

Now I do not understand why when you had a \$77 million surplus you did not help the people who have the worst problem in terms of military housing. Tell me why you did not.

VARIABLE HOUSING ALLOWANCE RATE CALCULATION

Mr. BERTEAU. Let us go back to the way in which we calculate the rates each year. I am a native of Louisiana. I am very familiar with the impact on housing and all the economy in oil-related economies, and it has been devastating in some areas.

Each year as we calculate the new rates in the variable housing allowance program, there are inevitably going to be some housing areas that go up faster than others and some housing areas that actually drop.

Senator STEVENS. Why do you base it on value of surrounding properties at all? Why don't you base it on the value of the property at the time the military person entered into the commitment to buy or lease it?

Mr. BERTEAU. We have to make sure we do not create incentives for people to try to maximize their VHA by entering into as high an agreement as they can.

Senator STEVENS. You can determine whether the original value was out of line. I do not have any problem with having comparable values at the time of the original approval of the eligibility. But why annually change what the home is worth because of the comparison to what someone on either side has sold or rented for when the military family is still in the same unit, paying the same cost that it had been paying and everyone else is getting an increase.

By the way, this year you have announced a 6 percent hike, notwithstanding the fact that the people in my State are all getting a decrease, and they are all living in exactly the same housing?

Mr. BERTEAU. Yes, sir; I understand that.

Senator STEVENS. That is not fair.

Mr. BERTEAU. As I understand it, the way in which the law reads is that we are aiming for an average of 80 percent coverage.

Senator STEVENS. You wrote the law. I opposed it at the time. You wrote it and this committee opposed it. Now do not quite quote to me that law because it was wrong at the time the Department sent it and it is still wrong now.

Mr. BERTEAU. I am only trying to elaborate on the way in which we arrive at doing that. I probably do not need to go into any detail on that. But as we built the 1989 rates that we are under right now, we deliberately built them somewhat conservatively because of the experience we had last year when we literally ran out of money because we had not calculated optimistically.

Senator STEVENS. I want you to do something for this committee and I think it would be very informative to the people of this community. It is my feeling that because of VHA costs in the Nation's capital escalate at a minimum of 6 percent per year. I want you to go back and run the rent-plus days and what was the escalation in value of homes where there is military impact in metropolitan Washington, and run a computer on the VHA days.

You have assured homeowners that rent their places here at least a minimum of 6 percent increase for military families. As a consequence, the rent increase all over the area is more than 6 percent a year. You have assured that people—if the sales next door go up, notwithstanding the fact that they are still paying the same mortgage, they get more money here.

In other words, if I moved into a home here when you put in VHA and I was paying \$1,000 a month, you have increased that because my neighbor paid \$1,050 and the next neighbor paid \$1,100 and then \$1,150 and \$1,200. You have increased it every year, notwithstanding the fact I am still paying \$1,000 under the terms of a long-term lease.

Yet my people up north that enter into an agreement to pay \$1,000 and now their neighbors are paying \$800, \$750, \$650, they are still paying \$1,000 and you are paying them less. I have never seen worse stupidity in my life. I am serious. I cannot understand people who would defend a system like that.

I frankly want to tell you I am going to attack it on the floor if it is not changed by the authorization committee. I am going to attack it every day I get a chance to do it this year. Because all over the country where I have gone, in oil country, where there are military people they are suffering now because of this system.

Yet here in this community we all know we have had a staggering increase in values, rental values and home values, here and I think it is brought about by VHA. There is no increased demand for housing here. There is just an increased awareness that if you are in Government and you are eligible for a Government supplement to your rent or mortgage payments you are going to get it and you are going to get it. As long as it goes up, you continue to get a windfall.

Mr. BERTEAU. We will be glad to run that comparison and provide you with that.

Senator STEVENS. Also give me some idea how many military families own this housing here.

Mr. BERTEAU. I do not know that we have records of who owns and who does not, sir, because we do not calculate or pay the VHA based on ownership.

[The information follows:]

VARIABLE HOUSING ALLOWANCE PROGRAM

Since D.C. area Service members were never covered by the rent-plus program, we do not have rent-plus data to use for comparisons. However, data from the Bureau of Labor Statistics, shown on the following table, indicate that prior to 1981 when VHA was first implemented, housing costs in the D.C. area grew more than 6 percent per year. Since 1981, when VHA started, housing price growth in the D.C. area has been less than 6 percent each year through 1988. Inasmuch as military personnel represent less than 5 percent of the D.C. area housing market, changes in VHA rates cannot be the basis for changes in housing costs in the area.

Bureau of Labor Statistics—Housing index [CPIU] for the Washington, DC area

	Percent
1976-77	7.6
1977-78	8.8
1978-79	11.3
1979-80	12.7
1980-81	11.2
1981-82	5.9
1982-83	4.5
1983-84	5.2
1984-85	5.0
1985-86	4.3
1986-87	3.6
1987-88	3.8

VHA increases only if actual rents reported by Service members on the VHA survey increase. If all of the Service members' costs stay the same, VHA will not increase. VHA rates will only increase if the local median housing costs in an area increase more than national median housing costs. However, if a Service member's housing costs are less than total housing allowances, that member's VHA will be reduced under the VHA offset program.

VHA decreases occurred only in areas where actual housing costs reported by military members resulted in local median housing costs that decreased or increased at a lesser rate than the national median for the paygrade. A team from the Per Diem Committee [PDTATAC] staff visited a number of locations in Alaska in April 1988 and found that the housing market was depressed and that most landlords and tenants would not enter into long-term leases (the average lease was for 30 days). Landlords were willingly renegotiating rents to keep people from moving to places which offered lower rents. Few renters were subject to leases of more than a year.

The housing situation in Alaska, which was documented by the VHA survey and confirmed by the PDTATAC staff visit, was verified by the fair market rental schedules proposed by the Department of Housing and Urban Development [HUD] (see Federal Register, Volume 53, Number 71, Wednesday, April 13, 1988), which recommended a 10 percent decrease for all locations in Alaska based on decreases in local consumer price indexes [CPIs]. The housing cost changes in Alaska which prompted this HUD recommendation occurred at about the same time that the Department of Defense was conducting the 1988 VHA survey which resulted in sizable reductions in VHA rates in most locations in Alaska.

Senator STEVENS. But you know the difference in your system.

Mr. BERTEAU. We do know the difference in terms of the local economy in all 350 areas that we look at.

Senator STEVENS. You know the difference in terms of the payments. You get a different VHA payment if you own as compared to leasing because you get some additions to your payment if you are an owner. As I understand it, the base is different.

If I rent, I get \$1,000. If I own it, then I have got some additional payments that go into the base of what it costs me for that house. Mortgage payments are less but they are about even when you put in your insurance and your taxes. You have some additional information that comes in on a person that owns a home as opposed to one that leases a home.

I think you can run it. One of the things that is happening is I think there are more people who are assigned here for a short period of time that hold onto those homes because they know this policy, and they know that if they continue to pay \$1,000 a month total for their home they are going to eventually keep getting 7 or 8 percent more per year return on that.

Mr. BERTEAU. That may well happen. It is obviously not our intention to provide incentives for active duty members to buy homes versus to rent homes. That is not the intention of the VHA pro-

gram, and if it is an accidental side effect, then perhaps we need to take a look at that.

[The information follows:]

VARIABLE HOUSING ALLOWANCE PROGRAM

Military personnel represent less than 5 percent of the D.C. area housing market and, therefore, do not have a significant impact on housing costs in the area. Furthermore, our data shows that 48 percent of the Service members in the D.C. area rent and 52 percent are home owners.

VHA rates for owners and renters are identical and are based on renter costs. Every Service member is eligible to receive the VHA rate established for the appropriate paygrade and location. However, due to the VHA offset, VHA payments vary depending on Service members' actual housing costs compared to their housing allowances. In determining housing costs for offset purposes, all Service members use the total of rent/ mortgage, utilities, maintenance, and insurance costs. Owners can never receive more VHA than the rate established for their paygrade and location, so ownership cannot result in increased VHA.

Property values influence VHA rates only to the extent that they affect rental costs. VHA rates, based on member-reported costs, are adjusted to ensure that military families receive increased housing allowances when their housing costs increase. The VHA system serves to provide the greatest help to Service members in locations where rental costs are increasing the most in order to maintain equal out-of-pocket costs for personnel in the same paygrade no matter where they are assigned.

Mr. BERTEAU. But I will run those facts and provide you with those.

Senator STEVENS. This was supposed to be a variable housing allowance on top of the basic allowance for quarters. The basic allowance for quarters was supposed to be based on rank and the variable housing allowance was supposed to be based on need.

Mr. BERTEAU. Yes, sir.

Senator STEVENS. But you only recognize need as the values of surrounding properties go up. You do not recognize need when the values of the surrounding properties go down at the very time military families need greater help.

Mr. BERTEAU. Again, I recognize that that is a serious situation for some families. But it is my belief and my view, from having looked at this over the last 3 years, that those cases are the exception rather than the rule. The program as a whole works very well in terms of accommodating the changing economic impact on military families as they move from place to place, community to community, around the country.

Senator STEVENS. Maybe you ought to tell us how many went up and how many went down this year.

Mr. BERTEAU. I would be glad to.

Senator STEVENS. I think you ought to give us an analysis and I am going to ask the GAO to do the same thing.

Mr. BERTEAU. I will be glad to do that. I think the number that actually went down this year is not at all out of line with our experience in previous years, and I will be glad to provide that.

Senator STEVENS. That is your experience with VHA. You know, that is like telling me the system works, Senator, because I devised it. You know, you ought to go out and talk to the people who are involved to see whether it works, not the Department.

Mr. BERTEAU. I have done that. I am aware.

Senator STEVENS. I am sure it is a very convenient system for the Department. You have a \$77 million surplus, you just run the com-

puter and everybody gets the same amount based upon what we already gave you. It is easy to say everybody gets x percent of what we gave you because what we gave you was right. Right?

Mr. BERTEAU. It is a very complex system that we use today. It takes quite some time to do the calculations.

Senator STEVENS. I am sure there are a lot of people that are working with slide rules and other things to figure it out, but when it comes right down to it it is the most unfair system I have ever seen.

Mr. BERTEAU. Well, I will be glad to provide the additional material that you have asked for, including the details of how many went up, how many went down, and where, and by how much.

[The information follows:]

VARIABLE HOUSING ALLOWANCE PROGRAM

The January 1, 1989, VHA rate change resulted in lower VHA rates in virtually all locations where VHA is paid, except coastal regions. The changes, ranging from a few cents to over \$150, were based upon the latest biennial housing costs survey data, a 7 percent BAH rate increase, and the funding limitation on VHA. A summary of recipient rate changes follows:

HOUSING ALLOWANCE PROGRAM

Number of recipients	Percent of recipients	Average VHA change	Average total housing allowance change
311,207.....	34	+ \$28.50	+ \$52.36
43,512.....	5	(¹)	+ 23.00
382,515.....	44	- 23.55	- .55
151,192.....	17	- 50.40	- 27.40

¹ No change.

The rate reductions reflect the Variable Housing Costs Survey data and were imposed by the Department in compliance with 37 U.S.C., Section 403a, paragraph (e)(2)(B) which requires the lowering of, "the rate for a paygrade in a survey area in accordance with a decrease in housing costs . . . reported in the variable housing allowance survey." Generally, housing costs reported in the survey reflect local economic factors which impact on housing costs for the public at large. In economically depressed areas such as those military localities in oil producing regions where housing costs decreased in the mid-1980's, members' survey reports correspondingly decreased. Conversely, in other areas where local economies prospered, VHA survey data correspondingly increased. In all cases, VHA rates reflect median member costs. Those members experiencing the higher costs receive the highest rates with all members retaining equal out-of-pocket costs in actual dollar outlays.

DEPENDENTS OVERSEAS

Senator STEVENS. Let me go to one other thing that bothers me a little bit. Despite the fact that the Congress has been trying to see about limiting the number of people overseas, it is my understanding that we continue to have an increase and particularly in terms of dependent support overseas, that this budget will spend \$3.6 billion next year to support dependents overseas.

We are doing that in spite of the fact that currency exchange costs continue to increase. We have got, I am told, 473,000 military and civilian dependents overseas. Is the Department, from a policy point of view, trying to see if somehow we might save the costs and find some way to have incentives for people not to go overseas with their military families?

Mr. BERTEAU. We are continually looking at that, and I am aware of those numbers. The vast majority, over 400,000 of that 473,000, is of course active duty military dependents. Somewhere about 50,000 or 60,000 are civilian dependents.

The down side of it, of course, and the part of the equation that you have to calculate each time you consider doing this, is the impact on our capability, the impact on the retention of our individuals, on their willingness to serve, and to take overseas deployments.

What is the impact if we in fact send them on short tours without their dependents? There is the impact on morale and retention. There is also an impact on cost because, in fact, it is not cost-free just to keep dependents here versus sending them overseas. If we do keep dependents at home, there are costs that go up over here versus going up overseas.

Senator STEVENS. Well, I wonder if taxpayers realize what is going on. We are going to close down production lines. We are going to limit the number of planes we produce, limit the number of tanks we produce, cancel a whole series of systems that are under development on which we have already invested a great deal of money, in order that you can have \$3.6 billion more to maintain more dependents overseas.

Let me tell you it is not all just the cost of them being there. I do not believe in separating families. But was it absolutely necessary to increase the cost of family housing operations by over \$300 million? Was it necessary to have increased construction by over \$70 million?

I really do not think that it is fair to people here to say we have got to put you out of work, you are no longer going to be a taxpayer in order that we can keep these people overseas in better, more expensive quarters, and hire more people to assist them.

I go into Japan. Everybody has got servants. I go into Germany. Everybody has got servants. And yet we are firing people here from the defense production lines because we have to balance these budgets. I think somehow or other there ought to be some different judgment going on in the Department in terms of these overseas costs.

Mr. BERTEAU. Two points, if I may, sir. One, the number of dependents who are overseas is a function of our forward-deployed forces overseas, where they are, and how long we need to have them there.

The number of dependents falls out from the forward-deployment policy. As long as we have a military presence in the places overseas that we have it, and with the rotation base that we have—that we have to maintain there—then the number of dependents does fall out from that.

FAMILY HOUSING

Second, the family housing O&M and construction money, as well as some of the school money, are targeted very specifically. Those increases in 1990 over 1989 are targeted very specifically at the huge chunk of lower grade enlisted members who do not have the kind of money that they can support their dependents in the

manner that you have described there, with servants and maids and so on.

The family housing is aimed at those personnel, and the family housing increases, both in O&M and Milcon, are increases from very low bases. The base of those in 1989 is a base that was reduced dramatically. If you look at the expenditures needed just to keep a bare minimum of annual amortization and replacement costs for the family housing that we have, we are barely at that level even with the increased dollars in fiscal year 1990.

We are going to run our family housing plant into the ground until it is dilapidated and falling apart if we do not spend money somewhere on that order of magnitude. I will elaborate for the record.

[The information follows:]

MILITARY FAMILY HOUSING

The increase of \$240 million for Military Family Housing [MFH] operations covers 2 fiscal years and includes Congressionally approved increases in housing leasing programs. MFH operations also covers the fixed costs of home ownership, such as utilities, the repair and maintenance of aging units, and the administrative and payroll costs involved in the operation of over 100,000 units of military housing overseas.

Currently, the average age of military housing is approximately 30 years and these units require increasing levels of repair. If we do not adequately maintain these quarters and lease or build new housing overseas, our military families will be forced to live separately or live in substandard housing on the civilian economy. The increased disruptions and stressors to these families will lead to decreased morale, productivity, and retention.

The fiscal year 1990 increase of \$70 million projected for MFH new construction is necessary to build approximately 978 units of family housing in three overseas locations. Clark Air Base and Subic Bay Naval Base in the Philippines require 666 new units. These units are urgently needed due to the substandard living conditions of these installations and the increased need for security due to terrorism. Ramstein Air Base, Germany requires 200 units of four bedroom housing for our larger sized families. This will greatly alleviate the long waiting list for adequate four bedroom housing on the installation. If quarters are not built at these locations, military families will choose to live in inadequate quarters off the installation or will have to live separately, thus adversely impacting morale and retention. When these housing units are constructed, a corresponding decrease in quarters allowances and overseas housing allowances will be realized. The remaining 112 units of new housing are projected for Keflavik, Iceland. Under the terms of the 1974 Memorandum of Understanding between the Governments of Iceland and the United States, all military-sponsored families and unaccompanied personnel are required to live on-base. No community support is available. Due to increases in unaccompanied tour lengths from 12 to 18 months, Service members are increasingly electing accompanied tours, to avoid prolonged separation from their families.

Senator STEVENS. We are closing a whole series of military bases in this country this year to save money, and I find family housing construction overseas going up from \$28.7 million to \$100.3 million. I find leasing going up from \$283 million to \$388 million, with projection into fiscal year 1991 of \$514 million, doubling in 2 years.

I think that is unreal. I think it is just unreal to put us in the position of closing down production lines for new systems to defend the country and building new quarters overseas. You have got existing quarters now. You are leasing existing quarters now.

I just do not see any reason for this increased cost overseas.

FAMILY HOUSING COSTS OVERSEAS

Mr. BERTEAU. In many cases those quarters are not of the kind of quality that you would be interested in living in or having your constituents live in. Many of them are in very sad shape, and what we have tried to do is target those for the changes, in terms of both the maintenance and construction money. I will provide more details for the record.

[The information follows:]

GOVERNMENT RENTAL HOUSING PROGRAM

A very sizeable portion of the increased housing leasing costs in fiscal year 1990 and fiscal year 1991 will result from the U.S. Army Government Rental Housing Program [GRHP] which will increase previously authorized leases by 17,400 during this time frame. GRHP funding is estimated at \$40 million for fiscal year 1990 and \$140 million in fiscal year 1991. Army funding will be transferred internally from the Military Personnel Accounts to the Family Housing Account.

Increases in lease funding requirements are caused by implementation of leases authorized by Congress.

Senator STEVENS. The overseas operations of the Department of Defense have been immune from cuts. We have not closed any bases. We have not reduced any people. And we have not reduced any costs. The costs have all been applied at the domestic military, and I agree they are not very good quarters, but they have been living in them for 10 years.

This year, in a very tight budget year, you decide to build new ones. Now I tell you from a policy point of view someone had better find the gear handle because someone has got his head up and locked as far as I am concerned. This is wrong, what is going on, and we have got to find some impact on it here.

I really do not believe that we ought to close down some of these production lines, and I think most of us do not. And yet if you look at where the costs are increasing we could do a lot with \$3.6 billion. Why can't you get along in 1990 with the money you had in 1989 overseas? Everybody is living. I have not gotten one letter from a constituent bitching about where they are living or what their allowances are or how they are treated overseas.

You want more percentage increase overseas than you do anywhere in the continental United States and you want us to close down a whole series of production lines and lay off people all over the country. I think that policy is wrong.

Thank you, Mr. Chairman.

Senator INOUE. If I may, let us shift a little gear here.

Senator STEVENS. I am sorry. With that, I have to go to make up a quorum in another committee.

Senator INOUE. I will be joining you soon.

ACQUISITION MANPOWER

I would like to look into the matter of personnel in defense acquisition, and I am looking at the numbers presented in the budget presentation.

From 1980 to 1988, through June 1988, the number of civilian personnel employed in defense acquisition grew approximately 44 percent, and the data also shows rather interesting service-specific

items. For example, the Air Force has three times as many military officers involved in acquisition as the other two services.

The Army has an extremely high number of acquisition personnel relative to their overall procurement budget. For example, the Army's procurement budget is less than half the Navy's, yet the Army employs 3,000 more military and civilian than the Navy in the acquisition area.

How do you explain this? Is there any uniform standard?

Mr. BERTEAU. One of my topics that I spend the most time wrestling with is in fact the definition of acquisition personnel and how many there are and why they are where they are. Let me address the two specifics that you raised but then talk the general problem as well.

AIR FORCE ACQUISITION PERSONNEL

The Air Force officers and the relatively large percentage in number of Air Force officers involved in acquisition vis-a-vis the other services, we have tackled that one head on as part of the officer reductions mandated by Congress and the DOD effort to clean up our requirements for officers in response to that study.

We actually have directed that the Air Force convert a substantial number of active duty officers to civilian jobs in the R&D and acquisition arena. I believe it is on the order of about 800. That trend is going to continue downward rather than upward.

In the Air Force's view, they grew those officers into those jobs rather than civilians because it was easier to get the engineers and the R&D people as active duty officers rather than civilians because of the civilian recruitment and pay problems that we were having earlier in the decade.

Nonetheless, it is difficult to argue that there is a military essentiality for many of those jobs and therefore under our standard policies those jobs need to be made civilian wherever possible, because if you cannot justify it on a military-essential basis or any of the other criteria that we use for active duty military being put in a job, then they should, in fact, be civilians, and we are moving very strongly in that direction.

ARMY ACQUISITION PERSONNEL

With respect to the Army and the number of people in the Army, the Army's procurement dollars are spread over fewer major systems and therefore the people per dollar measure, you have to take that with a certain context and framework. The Navy has a huge amount of its procurement dollars going into a relatively few line items—the ship construction and missiles and aircraft. Army has substantially larger numbers of smaller items and a lot more contract actions that result from that.

Nonetheless, one of the things that is being looked at or will be directed to be examined as a result of the management review, is the justification of those differences.

ACQUISITION MANPOWER OVERALL GROWTH

With respect to the overall growth that has occurred since the mid to early 1980's in acquisition and procurement personnel, these have been the result of three or four general trends which I would like to summarize. One, of course, was our response to the spare parts horror stories, which were generated, in part, by the fact that a lot of the contracting officers, the procurement officers who were actually working the specific contract actions, were so overloaded with work that they were literally not able, with the 30 or 40 open contracts that they were dealing with on any given day, to spend the time tracking line items. Where all you have is a national stock number and a price associated with it and you have got no idea what it is you are buying there, you may wind up buying an \$1,100 plastic stool cap, as happened in one case, for example.

One of the solutions to that problem was, in fact, increasing the number of people working those procurement contracting actions, so that the workload on the individuals would be reduced to the point where they actually could do their jobs right and make sure that those kinds of things would happen far less frequently.

The second trend had to do with the elimination of civilian ceilings. The Department then had the flexibility to evaluate whether or not it was more cost effective to do work with an in-house work force as opposed to a work force that was contracted out. Some of the growth in those numbers you cited actually are engineering services and work in the labs that we brought in-house as opposed to contracting out.

That makes our in-house personnel go up, but the overall cost goes down. And we had the IG look at that and he, in fact, verified that.

CONTRACTING PERSONNEL

Senator INOUE. Why the difference in the services? Why is the Army more than the Navy?

Mr. BERTEAU. The Navy actually did and does more contracting out and still does today. In fact, part of the response in the 1990 budget to that is the Navy is attempting and proposing to bring back some 1,000 spaces back in-house in fiscal year 1990 and an additional 744 in fiscal year 1991. So their own in-house work force size will grow. They, in fact, determined that, for both public policy reasons as well as for cost reasons, it is better to have that work done in-house, where you have better Government control over it than for having the contractors doing it.

Senator INOUE. Well, at the present time, the Navy procurement budget is double that of the Army, roughly. And yet the Army hires 3,000 more than the Navy.

Mr. BERTEAU. In part it is because of the size of the contract actions that they are working. If you have more contract actions, smaller dollars, you have more people working them. You have to look at the average size of the contracts in addition to the pure dollar total. The Army awards approximately one-fifth more contracts than the Navy, which roughly corresponds to the Army's higher number of acquisition personnel.

I am not saying it is perfect, but that is the fundamental reason why that difference exists, that there is a difference in the size of the contracts and the number.

Senator INOUE. You began your response to my question by saying that this is one area that is confusing, because you have no clear picture of what an acquisition person is.

Mr. BERTEAU. You have many clear pictures actually. You have different definitions for different purposes.

Senator INOUE. Don't you have a standard job description?

ACQUISITION—DEFINITION

Mr. BERTEAU. You do. But what you have is a problem of what is acquisition.

Senator INOUE. Don't you have a definition of acquisition?

Mr. BERTEAU. Yes; but you have a broad definition and then you have a more narrow definition. The broad definition, as included for example in the charter of the Under Secretary for Acquisition, covers everything from the front-end requirements determination process, which may be done by people who certainly do not look like acquisition people—they are actually active-duty military soldiers talking about what kind of aircraft we need and what kind of ships and missiles we need, et cetera—all the way to the maintenance people, the wrench-turners, and the repair shop maintainers.

When we are talking the acquisition work force that you are referring to here, we are talking about a more narrow spectrum of that population—not including the people working in the shipyards or the aviation depots, doing the repair work. By removing maintenance, that is a big chunk that you take out with the more narrow definition. Removing maintenance and logistics personnel is valid, because they do not actually affect the procurement process; they are part of the larger acquisition system in a cradle-to-grave sense, you know, from the time a system becomes an idea in somebody's mind, until the time we put it in the junkyard.

The broad definition of acquisition says, "Anybody associated with that system through the whole life cycle is an acquisition person." That definition captures almost 600,000 people, because it has got all the shipyards, it has got all the aviation rework facilities, it has got all the depots, and so on, including a huge blue-collar work force.

The more narrow definition includes only the people who actually work the procurement process, spending the R&D dollars, spending the procurement dollars, buying the spare parts after a system is fielded, et cetera. That definition is more closely aligned with the one that you are referring to here, roughly on the order of 180,000 to 200,000 people.

You can have an even more narrow definition, in fact, which is the procurement people actually working in the acquisition organizations and commands, because you do have contracting officers working for virtually every field activity or installation anywhere that will buy something at the local level.

What I am talking about is really a qualitative difference between a person working to procure weapon systems, communication systems, et cetera, versus somebody at the local installation

who is buying the Xerox paper to feed into the Xerox machine, or who is buying the postage meters, or something at the local level.

There is a qualitative difference there, and if we are looking at controlling the acquisition system and improving the acquisition system, we are trying to focus primarily on those people that are involved in the defense-wide systems, R&D and procurement arena.

That is the thrust of our efforts. That is why I talked about different definitions for different purposes.

DRUG INTERDICTION ROLE

Senator INOUE. After about 40 hours of heated debate, the Senate last night passed the \$3 billion supplemental appropriations bill, about half the time was spent on one item, and that is the \$300 million appropriation for drug interdiction.

One of the reasons for the extended debate came about because we really had no idea what the President meant when he spoke of providing \$300 million in drug interdiction. We did not know, for example, how much he set aside for procurement, how much for personnel. We really did not know what was involved. In fact, the new Bush budget does not request any appropriation specifically for drug interdiction. The Department's position was that it will make \$300 million available from within its budget.

Now, what are we supposed to gather from all of this?

Mr. BERTEAU. First of all, Secretary Cheney has made it clear that he intends to spend at least as much in 1990 on those areas that we are going to spend in 1989, whether it be O&M, procurement, Guard and Reserve expenditures, et cetera; and that it will be absorbed within the existing line items, or, where necessary, additional money would be moved in order to accommodate that. I do not know if that would be necessary, in any case, but if it were, then that would be covered that way.

The Secretary has made that repeatedly clear, both to us within the building and in his public statements.

Second, the \$300 million for fiscal year 1989 is being worked, in terms of the specific items that would be procured with that money and the specific program elements that the money would be spent on.

While I do not have the final product on that, my guess is that it will be forthcoming very shortly. And, of course, the committee will be provided with that as soon as that decision is made.

Senator INOUE. We would appreciate it, because we would hate to go through another exercise with Senators coming up with amendments to take out money when moneys do not exist, or not knowing where the moneys are.

Mr. BERTEAU. So would we. And I am personally surprised that it has taken us as long as it has. But, on the other hand, there were far more than 300 million dollars' worth of requests from the various CINC's and military departments as to what we could spend the money on. So we have had to go through the typical process of winnowing it down, prioritizing, and coming up with a comprehensive and coherent package that makes sense, based upon that.

When people see a free pot of money, they all rush for it, they would all like to get their share.

Senator INOUE. We would like to have it as specific as possible if we are to ward off any of these amendments.

Mr. BERTEAU. I will give you what I have now, immediately, for the record; and then as soon as we have a more detailed breakout, we will provide that as well.

[The information follows:]

FUNDING FOR DOD DRUG MISSION

To date, the OSD Comptroller has transferred \$30.239 million to the Military Departments to support state-level enhanced National Guard operations. Plans for spending the remainder: (1) \$10 million to the states for additional enhanced National Guard support; (2) \$60 million for acquisition of communications equipments to support the integration of command, control, communications, and technical intelligence assets dedicated to drug interdiction into an effective communications network; (3) \$100 million will be used for sensor support; (4) \$39.0 million will be used to enhance and ensure fundamental military communications connectivity to initiate networks between sensors, intelligence sources, fusion centers (target and tailored intelligence support) and law enforcement command nodes in order to perform DOD's detection and monitoring mission; (5) \$17.0 million to cover costs associated with start-up costs for the fusion centers; (6) \$19.0 million to upgrade baseline ADP capability at fusion centers to process data and support analysts; (7) \$18.0 million to increase operational flying hours and steaming days in support of detection and monitoring mission; and (8) \$7.0 million for various miscellaneous costs associated with DOD activities providing nonprogrammed or budgeted support to the detection and monitoring mission. On May 17, we completed full program review of requirements submitted for DOD's counterdrug effort. We plan to accomplish transfer of the operations and maintenance monies in June. Documents to support the required reprogramming of necessary funds to procurement should start reaching the Congressional Defense Committees in June.

MILITARY HEALTH CARE SYSTEM

Senator INOUE. I have been advised by several of my colleagues on the committee that they are waiting for the next opportunity to take a crack at it again.

Mr. BERTEAU. I appreciate your advice on that, and we will do our best to make sure that there is an appropriate framework for that to occur.

Senator INOUE. I realize that the health care system does not fall within your jurisdiction, but since it does involve personnel, and I am certain you have read that there are shortages in many critical medical specialties, from surgeons to nurses, and some of these shortages go into double digits, in your opinion, does treatment of dependents and retirees in military hospitals contribute to readiness?

Mr. BERTEAU. It does, and in two different ways. One, obviously, is the impact on the individuals, in terms of their morale, their propensity to enlist, their propensity to stay in the service, based, in part, upon that medical care. The implied contract that we have with the active duty member and with the retirees for that medical care is very important, and in many cases, is the number one reason why people elect to stay versus leave, and these are the people that we would like to have stay.

So for that reason it contributes very strongly, albeit indirectly, to readiness, by virtue of our ability to retain the people that we need to retain.

In addition, and this is one that we have spent quite a time wrestling with, and it is not easy to quantify, but there is a relation-

ship, in fact, between the wartime requirements and the peacetime health care needs. It is not a one-to-one relationship; there are a lot of skills and jobs that the medical care personnel do in peacetime that do not relate to what their wartime responsibilities will be.

On the other hand, there are a lot that do relate to what their wartime responsibilities would be. And we have looked very hard at ways in which we can expand that cross-relationship, by cross-training, for example; where we take people whom we need for peacetime medical care and, in fact, cross-train them in some of the related, but not directly the same, skills that they would need to be doing in wartime.

Since we build up this huge medical care system for peacetime purposes, we want to maximize our use of that capability in a wartime situation if it were to come to that.

WARTIME MEDICAL REQUIREMENTS

Senator INOUE. Do you believe that we can provide this health care if we are thrust into a wartime situation?

Mr. BERTEAU. We have looked at a couple of issues associated with that: What our wartime requirements are, in specific scenarios overseas. And we have two aspects of that: Our immediate shortfalls and our shortfalls over the long-term, when we have activated the Guard and Reserve.

The shortfalls overall for the immediate, early situation are not particularly dramatic overall, but there are certain skills, such as the surgeons that you mentioned, where the shortfalls are still significant and substantial.

Over the longer term, the Reserve shortfalls remain even more substantial and need continued effort to get the people into the Reserves that we need. And as you know, we have taken a number of steps: expanding the potential time frame that people can enlist, increasing the advertising and recruitment, increasing the bonuses, et cetera.

The other aspect of that is the equipment necessary, because it does not do you any good to have the personnel if in fact you do not have the deployable medical equipment for wartime. And we have made great strides in that area, in terms of our deployable medical systems and overcoming the shortfalls that we had in that regard to where we can almost see the light at the end of the tunnel, depending on the resource availability over the next couple of years.

So we have made a lot of progress; we are not there yet, but we are a heck of a lot better off than we were 2 years ago or 4 years ago or 6 years ago. And we believe we have a much better handle on both what we need and on how to determine what we need in both manpower and in terms of equipment, supplies, et cetera. And we are continuing to make considerable progress.

We are way beyond the point where you prepare by spreading sand on the decks to absorb the blood, and that is the medical readiness that we have, but we have still got a ways to go.

Senator INOUE. The subject that we are discussing this morning is very complex and technical as you have pointed out. Accordingly, I would like to invite you to look over your testimony and to

submit an addendum or clarification, if such is necessary, because this is the record on which we will have to make our decisions.

Mr. BERTEAU. Yes, sir.

FOREIGN CURRENCY FLUCTUATION ACCOUNT

Senator INOUE. I would like to now touch upon your foreign currency fluctuation account. You have said that some of the problems that have existed overseas can be cured if this account can be used for personnel costs.

My staff has looked over the current balance in this account and found that you have about \$40 million remaining, which is inadequate even to take care of the shortfalls in the O&M accounts, much less personnel accounts.

What advantage is there to allowing military personnel accounts to participate in an account that appears to be bankrupt?

Mr. BERTEAU. Well, there are two aspects to that. One, is the account itself and our ability to predict accurately, up to 2 years in advance, what foreign currency fluctuations will be. And the other is the military personnel accounts' participation within that.

Let me address the first one of those. If, in fact, we were able to successfully predict, up to 1½ to 2 years in advance, where foreign currency would be—if I were able to do that, I certainly would not be in this business, I would be making a lot of money on the foreign exchange markets—the Department is certainly better than I am at that, but we still do not do as good a job as we would wish we could.

There are times, and this year will be one of them, where we will face some shortfalls within that because of the dollar—potentially. And I am not sure where it will come out, because the foreign exchange trends right now do not necessarily mean that the situation will get worse over the next 3 months of this year; they may actually improve a bit.

Nonetheless, it is important to have an account like that so that you can accommodate those changes within a framework that goes both ways, up and down.

In terms of the military personnel accounts' participation within this overall fluctuation account, you may well recall that when the account was first set up back in 1979, milpers was a part of the account. And a couple of years after that, the Department asked that it be withdrawn from that account because we did not have an adequate accounting system to be able to segregate changes associated with foreign currency fluctuation from other changes associated with changes in pay and benefits and that sort of thing.

In the years subsequent to that, we have developed accounting systems that are now in place and the tracking system is now in place for a currency change tracking system; we can in fact discriminate to a great level of detail between changes in military compensation overseas, the overseas station allowances, et cetera, that are based upon foreign currency fluctuation, and the changes based on other things.

So the problem that caused the military personnel accounts to be taken out of the foreign currency fluctuation account in the first place are gone now. Those problems do not exist. We can, in fact,

account for those changes and isolate them to a very detailed degree.

The overall problem of being able to budget a sufficient amount of money to predict the future of what foreign currency changes will be, that problem will remain regardless of whether the military personnel account is included in the foreign currency fluctuation account or not.

And for our purposes, we will continue to try to refine our ability to predict. But, from the milpers point of view, it will be easier to accommodate our failure to predict accurately if, in fact, the milpers account is included within the overall foreign currency account.

It is a rather convoluted answer, but it really will be to our benefit to be able to do that.

Senator INOUE. When the dollar gets stronger, does the account grow larger?

Mr. BERTEAU. It should. And we clearly have to resist, both within the Department and in the Congress, any tendency to make this a one-way account only. In other words, we fund when it is going the wrong way, but we take the money out when it is going the right way, because you have got a nice pot of money sitting there and you want to take it. We have to resist that. Our ability to have funds available to pay for increases in overseas station allowances caused by currency fluctuations will depend, in part, on your ability to resist that temptation.

CATEGORY IV'S

Senator INOUE. I would like to get back to the category IV's. I have had my staff carry on a very vigorous discussion with Army personnel on this matter, and they have been carrying this out now for about 4 months. We have been advised, notwithstanding what the Secretary has indicated or the chief has indicated, that the Army missed its recruiting goal in the first quarter of fiscal year 1989 by 471 end strength, and that they had to recruit 11 percent category IV's.

However, they go further, the military people, in suggesting that unless their luck changes, they could have to recruit as many as 16 to 25 percent mental category IV's.

Now, you have said that you are bringing it down to seven. What is the picture?

Mr. BERTEAU. The numbers that you quoted, of missing by 470 or so, and of the 11 percent category IV's in the first quarter, are accurate. Both our projections and the Army's projections of 7 percent category IV's by year end were arrived at independently; in fact, the staff accuse each other of having stolen the numbers, because they felt there was no way that they should come out as close as they did. We both projected that by the end of this year, we will be down to 7 percent for fiscal year 1989 accessions.

I am not aware of anybody, either informally or formally, thinking that it is going to be substantially more than that. And certainly not 16 to 25 percent. That is the first I have ever heard those numbers.

It is not a question of luck. We know where the people are. We know how to go get them. We need to make sure that we in fact put the resources there to do that.

In part, what we are seeing today in those first-quarter statistics that you have there, is being a victim of our own success. Certain elements of the Department have been predicting for the last 3 years that, in fact, we needed to be worried about this. But, last year, as we had for many years before, our category IV's were only 4 percent; our overall high school diploma graduates were well over 90 percent in the Army and for all of DOD.

RECRUITING RESOURCES

So the amount of money being put into recruiting resources, into the recruiters themselves, into their facilities, into the advertising money, and into the bonus money that was being paid, has gone down, and it has gone down fairly substantially.

We have turned that corner a little bit in 1990, and said it is time to push this back up, folks, because the warning signals are there. It is not a warning signal anymore; it is actually a watch; we have got problems in sight.

But, the models that we have, which have proven to be quite accurate over the last couple of years, clearly indicate that if we do apply those resources, if we get the resources we need, and we are not talking a substantial amount of dollars here, we can in fact make sure that we do not see the kinds of numbers you are talking about, of 16 to 25 percent category IV's; that we stay below 10 percent, which was the accepted Army objective when we laid out those objectives in 1985, a very acceptable objective, and, of course, miles below where we were when we were up at 28 and 30 percent category IV's in the late 1970's.

So we feel comfortable that, in fact, both the demand on the available population, which will bottom out in the next few years, and the need for the quality that we have, can be obtained if we, in fact, target the resources.

The quality and the numbers we get are very sensitive to the recruiting and advertising resources that we put forth there.

Senator INOUE. How much are we spending for recruiting and advertising?

Mr. BERTEAU. The total amounts of the entire defense budget, active and reserve, is somewhere around \$2.2 billion—between \$2.2 billion and \$2.3 billion. Of that, about \$1.5 billion is active duty and about \$700 million is Reserves. I can give you more detail by service.

Senator INOUE. Can you also tell me how much of that would be for advertising?

Mr. BERTEAU. I believe it is around a little over \$200 million. I will provide an exact figure of that for the record, but I believe it is a little over \$200 million. Somewhere between \$200 million and \$300 million is advertising. And the biggest chunk of that is in the Army.

Senator INOUE. Can you also tell me how much we spend for training films?

Mr. BERTEAU. That I do not know, and I will have to provide that.

[The information follows:]

DOD RECRUITING AND ADVERTISING RESOURCES—FISCAL YEAR 1989-91 ¹

	Fiscal year 1989 actual	Fiscal year 1990 amended	Fiscal year 1991 President's budget
Active components:			
Army.....	\$651.7	\$643.0	\$648.2
Navy.....	342.9	375.6	387.2
Marine Corps.....	190.0	191.8	199.7
Air Force.....	160.4	162.5	166.8
Subtotal ²	1,345.0	1,372.8	1,401.9
Joint programs ³	124.4	125.9	134.2
Active total.....	1,469.4	1,498.7	1,536.1
Reserve components:			
Army National Guard.....	275.5	271.3	279.5
Army Reserve.....	204.4	227.0	233.5
Naval Reserve.....	98.4	101.6	104.5
Marine Corps Reserve.....	24.7	24.3	24.2
Air Force Reserve.....	39.5	43.6	47.0
Air National Guard.....	46.0	49.4	50.7
Reserves total ²	688.5	717.1	739.5
DOD total resources.....	2,157.9	2,215.8	2,275.6

¹ Includes all funds identified as enlisted, officer, or medical recruiting resources. The cost of retirement accrual is included with military pay for all years shown. Excludes examining costs.

² For all years displayed, active force includes cost of kickers (ACF and NCF) while Reserves include cost of the GI bill.

³ All joint programs support both Active and Reserve components.

Note.—Numbers may not add due to rounding.

DOD RECRUITMENT ADVERTISING COST—FISCAL YEAR 1989-91 ¹

	Fiscal year 1989 actual	Fiscal year 1990 amended	Fiscal year 1991 President's budget
Active components:			
Army.....	73.6	83.1	83.9
Navy.....	15.5	20.2	22.4
Marine Corps.....	15.0	14.3	14.8
Air Force.....	14.9	15.3	15.1
Active total.....	119.0	132.9	136.2
Joint programs ²	31.3	30.8	32.4
Reserve components:			
Army National Guard.....	12.6	12.6	13.1
Army Reserve.....	20.6	23.4	23.4
Naval Reserve.....	4.4	3.1	3.5
Marine Corps Reserve.....	2.6	2.4	2.1
Air Force Reserve.....	3.4	3.7	3.8
Air National Guard.....	1.7	1.7	1.8
Reserves total.....	45.3	47.0	47.6
DOD total advertising.....	195.6	210.7	216.2

¹ When adjusted for inflation, the advertising budget reflects a continuous decline since fiscal year 1986.

² Joint programs support both Active and Reserve components.

Note.—Numbers may not add due to rounding.

COST OF TRAINING FILMS

Based on reported figures, the estimated production cost of training films and tapes for the Department of Defense was \$7,375,000 in fiscal year 1988.

HIGH SCHOOL DIPLOMA GRADUATES

Senator INOUE. Still on category IV's. I have been sitting on this committee for many years and whenever a witness appears to discuss personnel, like you, Mr. Secretary, they always differentiate, we have so many percent high school graduates. By high school graduates, are you assuming that all men and women with a diploma would be considered category III or better?

Mr. BERTEAU. No, sir; the testing that determines the category is based upon the actual scores on a very carefully normed test that does determine the mental capability. It is conceivable, I do not know what the numbers would be, but is certainly conceivable that you can have a high school diploma graduate that does not score in category I to III-A. In fact, the category IV's that we brought on active duty are all high school diploma graduates. I will provide that information for the record.

[The information follows:]

AFQT CATEGORY IV PERSONNEL

The Armed Services Vocational Aptitude Battery [ASVAB] is used to determine the enlistment eligibility of applicants and to assign qualified recruits to military jobs. The verbal and mathematical subtests of the ASVAB are combined to produce the Armed Forces qualification test [AFQT] composite. AFQT scores are grouped into five broad categories based on the following percentile ranges:

*Percentile ranges**AFQT category:*

I	93-100
II	65-92
III	31-64
IV	10-30
V	1-9

Individuals scoring in category V are precluded from enlistment by law. There is also a legal limitation on the proportion of enlistees who may have scores in category IV (each service is not to exceed 20 percent of the total number of its enlistments in any fiscal year). In addition, the law also requires that all category IV recruits be high school graduates. In fiscal year 1988, 5 percent of total accessions scored in AFQT category IV. Through the first half of fiscal year 1989, 7.7 percent scored in category IV. While this proportion is up from the preceding year, it is still less than half that is found in the civilian youth population.

Senator INOUE. Well, according to the Secretary of the Department of Education, and this was about 6 years ago, he said that 13 percent of high school graduates were functional illiterates.

Mr. BERTEAU. Not very many of those are going to make it through our test, sir. Because if you are a functional illiterate, on the Armed Force Qualifying Test, you are not likely to even score out as high as a category IV; you are likely to score out as a category V and not even be eligible for enlistment.

Even at 11 percent, we are not taking very many category IV's. The likelihood that we are going to have what the Secretary of Education referred to as functional illiterates enlisting in the Army is extremely low. I will provide more on that for the record.

Our training materials reflect that today. We no longer have the situation with the comic book instructional materials and so on. Our soldiers are not at that level.

[The information follows:]

LITERACY AND MILITARY RECRUITS

Since 1980, the quality of recruits has increased to unprecedented levels. Under today's recruiting policies, more than 90 percent of new enlistees score average or above on the enlistment test and have graduated from high school. These numbers compare favorably with the civilian youth population (where 69 percent score average or above and 75 percent have graduated from high school).

With regard to literacy, estimates of recruits' reading ability are obtained by converting enlistment test scores to comparable scores on a composite of commercial reading tests. While reading is an important aspect of successful service, we do not require minimum reading grade levels for entry into the various military occupations. Because our enlistment test correlates well with commercial reading tests, we believe that the aptitude levels required to qualify for skill training also ensure sufficient literacy for on-the-job performance.

Overall, recruits read much better than civilian youth of the same age. The average reading grade level of new recruits is 11.3, compared with 9.4 for the civilian youth population. In fiscal year 1988, the services did not enlist a single recruit who read below the 6th grade level (considered the cutoff for functional illiterates).

ENLISTMENT STANDARDS AND PERFORMANCE STUDY

Senator INOUE. Well, we have spent some money on a study to link enlistment standards to job performance. And the study apparently is still going on. When do we end this study? This is the so-called Armed Service Vocational Aptitude Battery.

Mr. BERTEAU. We are very close to the end of that now. In terms of time, we are about a year to a year and a half away from wrapping the whole thing up. And this is a very long study. As you know, generated, in part, by the misnorming episode in the late 1970's, where we took so many people in that were literally unfit for service, and virtually untrainable.

In terms of the dollars, we are probably at the point where about 90 percent of the dollars of that are behind us as well. There is only a couple of million dollars left to complete the work.

The study is a major, massive, and unprecedented effort to link actual performance on specific tasks to something that we can identify, in terms of enlistment standards, so that we have some legitimate predictors of how people are going to actually be able to perform after they have been trained for a job, based upon what kinds of criteria we apply at enlistment.

It is extremely valuable for us to be able to discriminate among the kinds of people that we want to bring in and where we want to put them, in terms of what skills we want to train them in.

We invest an awful lot of money in these people by the time they come out of a skill-training program, and the degree to which we can be better assured that they will in fact be able to do the job and will stay and do that job and successfully perform it, then that is the degree to which those training dollars will have been very well invested.

The total cost of this study is miniscule compared to the amount of money we spend every year on initial skill training.

BASE CLOSURE IMPACTS

Senator INOUE. The following question is important for a mark up that we hope will come around some time in July. Your Office of Economic Adjustment has the responsibility of assisting communities impacted by the base closures. The CBO has advised this committee that such adjustment assistance has been a major ex-

pense in past base closures. We have been told that planning grants have already been made to communities on the Base Closure Commission's list.

What we would like to know is whether you have an estimate as to your requirements that will result from the base closure recommendations? You see, we have to know what you need for the budget.

Mr. BERTEAU. The money that we have in 1989 is sufficient to this point. And we are already issuing planning assistance money to a variety of the communities that are affected. Lexington, for example, got an announcement just Friday night of about a \$100,000 planning-assistance grant to assist there.

We have been out on the road looking at all the various bases that are going to be closed, and meeting with the local community leaders, et cetera, and determining what kind of process and the timing involved, and so on.

Because the final timetable for the closing of all the bases has not yet been settled, we do not have an exact prediction of what we think we will need in fiscal year 1990. We should have that soon, and I would expect to be able to provide the committee with that in advance of your mark up schedule. And I will endeavor to do so.

Senator INOUE. Also, can you provide the criteria for the record?

Mr. BERTEAU. I certainly will.

[The information follows:]

PLANNING ASSISTANCE

For fiscal year 1990 we have budgeted \$2 million for planning assistance. The funds will be used to develop comprehensive plans for the community reuse of military property and facilities. However, implementation funds for infrastructure or other community needs will not be required until fiscal year 1992.

CRITERIA FOR PLANNING ASSISTANCE

The criteria for providing planning assistance funds to communities are in title 10 U.S.C. section 2391: "if the Secretary determines that an action is likely to have a direct and significantly adverse consequence on the affected community." We interpret this to mean a consideration of lost jobs, earnings, property values, inventory values, tax revenues, Federal and State funding, and other applicable economic indicators. . . .

Senator INOUE. Senator Kasten.

Senator KASTEN. Mr. Chairman, I have no questions at this time. I have a couple of questions I would like to submit for the record.

Senator INOUE. Mr. Secretary, I could go on all morning.

Mr. BERTEAU. I would be delighted if you wanted to.

Senator INOUE. But I have to report to the Rules Committee. We are having a problem there on quorum and the number of us being in attendance. So, if I may, I would like to submit the remainder of my questions to you for your consideration.

Mr. BERTEAU. Mr. Chairman, I will be happy to take those.

Senator INOUE. Once again to repeat my invitation that you look through the testimony, and if necessary, clarify or submit a supplemental testimony. I will ask my staff to sit with you to go through some of these problems, because this is a big area on our mark up and we would like to be certain that we are not making any mistakes.

Mr. BERTEAU. I appreciate the opportunity to do so.

SUBMITTED QUESTIONS

Senator INOUE. Once again, I thank you very much, Mr. Secretary, for being with us this morning. As I indicated to you, your testimony will be very important, even if the cameras are not here, your portfolio is the biggest.

[The following questions were not asked at the hearing, but were submitted to the Department for response subsequent to the hearing:]

QUESTIONS SUBMITTED BY SENATOR DANIEL K. INOUE

ENVIRONMENTAL RESTORATION

QUESTION: Mr. Secretary, I understand that your Office of Economic Adjustment (OEA) is working with the Defense Environmental Restoration program and various States to enhance cooperation on DoD's environmental cleanup program.

We understand that through memoranda of agreement, Defense and States will agree on priorities for environmental cleanup funding nationwide. Could you please elaborate on OEA's efforts?

ANSWER: The Deputy Assistant Secretary for Environment and a State working group have developed standard language for a DoD and State Memorandum of Agreement (DSMOA) to expedite the cleanup of DoD installations. The DSMOA describes means for the States and EPA to establish priorities among sites. It has been developed over several months and is in final negotiations.

OEA, because of its extensive experience with State and local governments, is providing technical assistance to the DoD Environmental staff. It is helping to develop administrative procedures for reimbursing States for services supporting the cleanups. These procedures will be implemented as Memoranda are executed.

MANAGEMENT REFORM

QUESTION: Secretary Berteau, the budget projects savings of \$286.1 million from the awaited "Management Review." Your background on the Packard Commission staff, in addition to your current position, should enable you to judge whether the Department's acquisition organizations need overhaul.

What specific changes in the acquisition system are proposed in the Management Review? Are we likely to be requested to abolish or significantly reduce Air Force Systems command or the Army Materiel Command?

ANSWER: The specific details and recommendations of the Management Review are not available at this time. When the President and the Secretary release the final copy of the Management Review, we will be able to discuss it in more detail.

The Department of Defense has established a Defensewide allowance for efficiency savings resulting from implementation of Management Review recommendations. The current DoD Budget Request reflects savings of -\$286.1 million in FY 1990 and -\$433.6 million in FY 1991 as a result of projected successful implementation of Management Review recommendations. I cannot discuss any more specific

recommendations until the Management Review has been formally released.

QUESTION: It appears that substantial changes must begin soon in order to produce savings of almost \$300 million. Do you agree?

ANSWER: Yes sir, I agree with your assessment. The Defense Department has in fact incorporated these resource reductions in its FY 1990/FY 1991 Budget Request. Service funding was reduced by -\$286.1 million in FY 1990 and by -\$433.6 million in FY 1991 as a result of projected successful implementation of Management Review recommendations.

When the Management Review is released, the DoD Components will implement the Report recommendations to achieve the savings built in to the Budget Request.

QUESTION: Secretary Berteau, you are uniquely well qualified to judge whether the "Management Review" fulfills the reforms intended by the Packard Commission. Does it do so?

ANSWER: I believe that the current Management Review will provide the framework and the opportunity for the Defense Department to fulfill the reforms intended by the original Packard Commission. However, once the Management Review report is issued, it will be up to DoD managers at all levels to insure that reforms are accomplished in a manner that improves quality and productivity throughout the Department while saving resources at the same time. The Defense Department will also need the active help and support of the Congress to implement many of the Report's recommendations.

MANAGEMENT OF CIVILIAN PERSONNEL

QUESTION: Secretary Berteau, I can recall many instances when Military Service witnesses have made personnel resource comparisons in terms of workyear or end-strength levels. In order to do this, it would seem the Department has, at least, recognized a need for some personnel restrictions. Can you tell the Subcommittee why DoD so strongly opposes Congressionally mandated personnel ceilings when the Department is, in fact, imposing such restrictions on itself? Is it because your ceilings are so much higher, or do you have specific objections?

ANSWER: Essentially, the problem with Congressionally mandated personnel ceilings is that such an approach places an unnecessarily heavy and thereby distorting emphasis on a single component of the Department's overall Planning, Programming and Budgeting System.

During FY 1986, DoD complied with the Congress' directive to manage our civilian workforce without controls on the numbers employed on the last day of the fiscal year. Consequently, the civilian work force is managed as a resource, not as a program.

The Department uses its resources (dollars, manpower, facilities, equipment) to accomplish its missions and undertake its workload. Its Budget is expressed and Congressionally approved on the basis of specific programs directed towards achievement of missions, and the dollar sum of the various resources required for program delivery.

Effective program delivery demands an ongoing process of judgements regarding the optimum mix of resources to be applied, and manpower must be regarded as but one element of a total resource mix. That mix can, and does, change during a Fiscal Year and during the life of a program. Changes in program emphasis can require direct offsetting between manpower and equipment, for example, within the same budget limits. They can also involve questions of the mix within manpower itself. Judgements on program effectiveness also need to take account of the total resources applied.

In the absence of ceilings, the Military Departments and Defense Agencies can employ more flexible, prudent, and cost conscious responses to problems, making maximum use, for example, of temporary workers and overtime to handle surges, and to raise productivity through capital investments, efficiency reviews, quality circles, and other initiatives.

In managing and accounting for the manpower component of its resources, the Department must estimate and plan for the human resources required for program delivery, and monitor the total effect of variations to those estimates. This is not to say that the Department is imposing personnel ceilings on itself, but rather that the Department is quantifying the human and dollar aspects of its personnel component in order to monitor and adjust its contribution to the total effort.

The success of this approach speaks for itself. In FY 1988, for example, the Department came within 0.1% of its budgetted work year target, and within 0.5% of its manpower budget.

QUESTION:

In past years, this Committee proposed the establishment of a civilian payroll limit. The Committee has criticized Defense activities, such as the Air Force Logistics Command, which have allowed personnel levels to become disproportionate to their

manpower budgets. As you know, the Navy has strongly advocated a "manage to payroll" system in lieu of an end strength ceiling policy.

Would you explain the "manage to payroll" concept. Has the "manage to payroll" concept been successful? Would you consider it to be an effective way to keep the civilian employment level commensurate with the Department's workload and budget?

ANSWER: First of all, let me be quite clear on the fact that civilian manpower has declined by 21% since the Vietnam years. The Reagan administration reversed this trend, increasing the civilian work force to support increases in missions and funded workload. While civilian employment levels peaked in FY 1986, they have been steadily reducing since that time due to implementation of a number of rationalisation programs. Our civilian end strength is budgeted to reduce by about 5,200 spaces in FY 1990 and another 3,200 spaces in FY 1991. The point I am making here is that the variations in manpower numbers should be viewed as the result of planned variations in funded workload, rather than a symptom of a porous manpower management system - as the background to the question might suggest.

The "manage to payroll" concept is applied in Navy and Air Force, and enjoys the full backing of OSD as a useful component of the overall Planning, Programming and Budgeting System. But in explaining it, I need to go back a step. Civilian payroll estimates are formulated on the basis of programmed workload and an assessment of the manpower required to achieve that workload. However, the subsequent management of the work force by payroll rather than mandated workyears and end strengths allows managers the flexibility to vary the structure of the work force, within overall costs, to meet actual workloads more efficiently and effectively. It is an execution tool rather than a formulation tool, designed to give line managers the ability to make decisions on required personnel classifications for the workload, and to consider such staffing options as lower graded or temporary employees or overtime where appropriate.

It is working quite well, and we are encouraging further refinements and developments in this direction. But I should add a note of caution against focusing simply on this one element of what is a total manpower management system within a larger resource allocation system. The ability of line managers to manage by payroll is still tempered, for instance, by a fairly close monitoring of civilian numbers by Military Departments. Significant departures from the budget require approval from headquarters. Such procedures allow the Services to keep employment close to budgeted levels while preserving the flexibility to

meet unexpected workload fluctuations due to emergencies or changes in priorities.

HEADQUARTERS PERSONNEL--VANDER SCHAAF REPORT

QUESTION: The "Vander Schaaf" Report, completed in February 1988, examined the military and civilian manpower in the Department's Unified and Specified Command Headquarters organizations. In December 1988, the Secretary of Defense submitted to Congress the Department's evaluation of the Vander Schaaf report. DoD determined that of the 7,309 spaces identified in the Report as unnecessary, 3,000 military and civilian spaces could be reduced "without seriously damaging the National Command Structure or military readiness.

According to your recent testimony before the Senate Armed Services Committee, DoD has decided to reinvest 2,244 spaces in support operations.

In light of current budgetary constraints, is reinvestment a sound management decision? Why is it necessary to fill these positions now when the Services have managed adequately without them in the past?

ANSWER: Actually, the Defense Department reinvested the 2,244 military and civilian spaces that were saved as a result of implementing Vander Schaaf Report recommendations in unfilled combat and combat support positions and in unfilled medical positions. We don't consider these areas to be traditional "support" efforts.

We believe that the reinvestment of the saved spaces into combat, combat services support, and medical support represent a sound management decision to devote more available resources to readiness-related functions while reducing overhead.

The combat, combat services support, and medical support positions were valid requirements which could not be filled because of lack of available resources. The investment of manpower in these areas improve the Department's overall readiness posture.

QUESTION: How many of those 2,244 spaces will be reinvested in support of medical operations?

ANSWER: We estimate that 939 civilian spaces were reinvested in support of medical operations as a result of the savings achieved by implementing the Vander Schaaf Report recommendations.

QUESTION: Where have these positions been added?

ANSWER: The civilian spaces reinvested in support of DoD medical operations have been distributed throughout the Army's and Navy's Service hospitals and medical facilities. These reinvested spaces are being

used for additional doctors, nurses, and especially for medical technicians.

MEDICAL CARE

QUESTION: Shortages in many critical medical specialties, from surgeons to nurses, have caused considerable turbulence over the past several years. Do you have confidence that our military health care system would be adequate, if we had suddenly to convert from a peacetime to a wartime mode?

ANSWER: The Medical Manpower Annex of the FY 1990 Defense Manpower Requirement Report (DMRR) to Congress contains the statement: "If the United States were to enter a major conflict today, critical shortages of health care specialists would hamper the nation's successful prosecution of that war." I agree with that assessment. Analyses showed there would indeed be serious shortages, especially for people with surgical, anesthesia and nursing skills.

To correct this situation the Department has placed special priority on providing adequate resources for recruitment of reserve medical personnel in the Fiscal Year 1990-1991 Defense budget. This request represents the minimum funding necessary to increase recruitment and to reduce wartime shortfalls of health professionals. The budget request includes vitally needed increases in Active Guard/Reserve (AGR) medical recruiters and in end strength for reserve medical personnel.

QUESTION: Does meeting peacetime medical requirements lead to an imbalance in medical skills -- that is, do we hire OB/GYN doctors for dependents and pediatricians for their children while neglecting critical wartime skills?

ANSWER: While the Selective Reserve is structured only for a wartime role, the active component must be structured to meet both a peacetime and wartime mission. In many ways the dual missions both complement and conflict with one another in their demands for health care personnel. The Department continues to emphasize initiatives to improve our capabilities for optimum wartime use of peacetime physician inventories. This past year, we studied ways by which we can partially satisfy our most critical wartime surgical shortages through enhancing the skills of specialists such as obstetricians/gynecologists and urologists. We were able to document that a substantial part of our wartime surgical tasks could be legitimately allocated to such physicians.

Toward this end, the Department implemented the

DoD Physician Wartime Skills Enhancement Program, one of our action plans under the Medical Readiness Strategic Plan. The initial program phase provided general surgical skill training for our OB/GYN specialists. This phase has been completed worldwide. We plan to begin the next phase later this year to provide orthopedic surgery skill training to family practice, emergency medicine, and physical medicine specialists. This specialized enhancement training will qualify these members of our active duty inventory to provide orthopedic services in wartime. We are exploring the potential for additional cross-utilization. For example, the Services plan to use pediatricians in a variety of roles such as flight surgeons, preventive medicine officers, and primary care providers in the most forward locations on the battlefield.

ARMY RECRUITING SUCCESS

Question: We have recently heard testimony from the Secretary and Chief of Staff of the Army that the Army has had great success in its recruiting efforts in the first two quarters of FY 1989, and that they will finish FY 1989 with no more than 7% of the year's recruits being in Mental Category IV. Further investigation indicates that the Army achieved this result only by drawing down the resources of the Delayed Entry Program (DEP), thus creating a potential problem in FY 1990. Would the Army have met its recruiting goals so far this year if there had not been an end strength reduction?

Answer: End strength levels are only one factor involved in computation of the actual number of accessions the Services want to bring on board in any given month. The other key factors are actual retention experience, strength deviation (budgeted versus actual workyears), and training course entry schedules. Although the Army has reallocated new accession objectives from the first half of FY 1989 to the summer months, it is closer to its budgeted strength plan this year than in either FY 1987 or FY 1988. Consequently, it is not clear that the rescheduling of new accessions resulted from an anticipated end strength change.

Question: What effect will the Army's action in drawing down the DEP in FY 1989 have on recruiting in FY 1990?

Answer: As of the end of April, the Army had accessed (or contracted for accession) 87 percent of its FY 1989 recruiting objective. While this is 6 percentage points below the level achieved in FY 1988 (and 5 points below FY 1987), it is 3 points above the level achieved by the

Air Force in FY 1987 and 4 points higher than the Navy reached this year. We consider it within an acceptable range. The proportion of the Army DEP that is comprised of high quality applicants (high school graduates with AFQT scores in Categories I-IIIa) is slightly above the level at the same time in FY 1988. In previous years this proportion has fluctuated from month to month, with changes of more than 10 percentage points and frequent changes from positive to negative slope (or vice versa) common. However, this year the proportion is less volatile. The range of fluctuations has been less than 10 percentage points, and a consistently downward trend has developed since November. This is largely responsible for our support of Army legislative and funding initiatives to arrest negative recruiting trends. Looking to FY 1990, the DEP is one percentage point smaller than at this time in each of the 2 previous years. The FY 1990 budget request and related legislative initiatives adequately support Army quality recruiting needs.

VARIABLE HOUSING ALLOWANCE PROGRAM

QUESTION: Secretary Berteau, this subcommittee has recently learned that there is a \$77 million surplus in the Variable Housing Allowance (VHA) account and that the Department is using this surplus to increase VHA payments by an average of 6 percent, effective June 1.

Last year, when the FY 1989 Defense appropriations bill was being considered, the Department discovered that the Navy had understated its VHA requirements in FY 1988 and in FY 1989. Accordingly, when the conferees on the DoD bill set the FY 1989 appropriation for VHA, the VHA allowance was increased by \$73 million ABOVE the budget request to accommodate this miscalculation.

Why does the Department feel that a bonus should be paid for VHA rather than using this unexpected surplus to fund other shortfalls, such as overseas station allowance, within the Military Personnel accounts?

ANSWER: First, I would like to clarify what the \$77 million figure represents. There is not a surplus of \$77 million in the FY 1989 VHA account. The appropriated level of funding for FY 1989 is only \$1.148 billion. The \$77 million represents the difference between the VHA statutory ceiling, \$1.220 billion, and the end of March 1989 projected VHA expenditures for 1989 of \$1.143 billion--a difference of only \$5.0 million under the appropriated levels.

As far as helping Service members experiencing the worst needs in terms of military housing with the recent VHA increase, we believe we did. The problem most disconcerting to Service members occurs when housing costs grow, but housing allowances do not increase

at rates/levels necessary to cover costs, thus forcing Service members to absorb a greater portion of their housing costs. The January 1, 1989, VHA rate changes were calculated to accomplish the VHA program goal of equal absorption for Service members of the same pay-grade no matter where they are assigned. Housing cost growth, as measured by the 1988 VHA Survey, revealed significant increases in some locations and sizable decreases in others, with a wide range of changes nationwide. Therefore, to keep absorption equal, VHA rates were changed in the same way. If we had prevented decreases, we would not have been able to provide the more needed assistance to the members in the high cost-growth areas, thereby severely disadvantaging these members relative to the low or negative cost growth areas. It is important to note, also, that VHA rate changes always follow changes in member-reported housing costs, and since VHA rates are based on median costs, a significant number of Service members must have reported changes in order for the median, on which the VHA is based, to change.

The value of surrounding properties is not the basis of VHA rates. VHA is based on actual rental costs as reported by Service members on the VHA survey every 2 years. Individuals with long-term leases are just as likely as anyone else to be surveyed and have their costs, which may be higher in areas where costs are decreasing, used in computing VHA rates. Home owners' monthly payments are not used to compute VHA. Actual home owner costs are used only to determine if a member is subject to VHA offset.

The intent of VHA is to provide military personnel housing allowances that will enable them to secure adequate housing in the area to which they are assigned. It was decided at the outset of the VHA program that rental expenses, rather than home owner costs, were a more appropriate measure of the housing expenses that VHA should cover. This is consistent with the long-standing approach the Department and Congress have taken in setting allowances for housing when government quarters cannot be provided. There are two major reasons for this:

(1) Home owner outlays do not measure the "true cost" of housing--a determination of true cost for home owners would require consideration of a host of complex factors, such as amount of downpayment, taxes, equity build-up (or loss), etc. The use of rental equivalency dampens out the investment and tax advantage aspects of home ownership.

(2) Home ownership versus renting is a personal preference of the member. The decision to buy--with its attendant risks and rewards--is made voluntarily by the member and should not be subsidized by the government through the military housing allowance. We do use home owner data regarding type of structure and size (number of bedrooms) of dwelling when computing VHA rates. However, much like the Bureau of Labor Statistics in determining housing cost growth in the Consumer Price Index (CPI), we use a

"rental equivalency" as the measure of housing cost for home owners.

The VHA system does not affect what the home is worth in any way. Service members' actual reported rents for similar (type structure and number of bedrooms) dwellings are used to determine rental equivalencies for Service members who are home owners. The rental equivalencies, rather than the actual home owner costs, are then used for computing VHA in various locations.

By law, VHA is based on the median cost of housing in every locality. As a result, VHA reflects the typical costs in each area rather than the actual cost experience for individual members.

The VHA rate increases which took effect June 1 apply to everyone drawing VHA, including Service members in Alaska. Service members who are subject to VHA offset will receive smaller increases than the maximum announced for their paygrade, but they will still receive an increase.

Even when VHA rates were changed January 1, 1989, not all members in Alaska had their VHA reduced; some Service members in Kodiak had increased VHA, including increases of \$16.81 for E4s, \$19.87 for E9s, and \$15.15 for O3s.

The January 1, 1989, VHA rate decreases in Alaska were based on the 1988 VHA survey, which showed that Service members were taking advantage of the lower housing costs stemming from the drop in oil prices and reported lower housing costs than they had on the previous survey done in 1986. Thus, the drop in median housing costs which resulted in lower VHA rates was based totally on actual rental costs reported by Service members in Alaska.

The recent VHA rate increase is not a bonus. VHA rates established January 1, 1989, were constrained in order to comply with the \$1.220 billion statutory funding ceiling imposed by Congress. Service members eligible to receive VHA since January 1 have received less than the law allows because of the ceiling. After the FY 1988 experience, when VHA expenditures would have exceeded the ceiling had it not been for some last minute creative rate adjustments, the Department had to ensure that VHA spending in FY 1989 would not exceed the ceiling. Accordingly, the rates were set at a level which would not result in outlays exceeding the ceiling, but could be increased later in the year if actual and projected expenditures permitted. Since FY 1989 VHA expenditure data, as of the end of March, indicated that we would be under the ceiling, the Department felt it was appropriate to increase VHA rates and thereby reduce out-of-pocket costs and bring VHA recipients closer to the 15 percent absorption Congress intended when VHA was revised in 1985. Funding other shortfalls in the Military Personnel Account rather than increasing VHA would have meant denying Service members who live off-post in the United States increased allowances they were properly entitled to receive.

The VHA rates which became effective January 1, 1989, were set to ensure that out-of-pocket costs for individuals in the same paygrade were the same regardless of where they were assigned. In order to preserve equal out-of-pocket costs when the rates were increased June 1, 1989, equal dollar increases (not percents) were given to each paygrade. Any other method of accomplishing the rate increase would have resulted in Service members in locations that received larger increases having lower out-of-pocket costs than Service members of their same paygrade who were stationed elsewhere. Such a situation is contrary to the basic philosophy of the VHA program.

QUESTION: I notice that there is a small reduction in VHA between the original January budget submission (\$1,225,973,000) and the amended request now before us (\$1,222,136,000). Do you have confidence that DoD can remain within the budgeted amount for FY 1990?

ANSWER: Yes. The only reduction to VHA is that which is associated with the reduced force structure.

Drug Interdiction Spending

Question: Mr. Secretary, the Department's drug interdiction proposal with respect to the Guard is difficult to understand. Is the Department proposing that the Army and Air National Guard fund drug interdiction activities from within existing funds?

Answer: The Department is committed to providing \$318 million from within existing funds to support FY 1990 DoD drug interdiction efforts including support provided incidental to training. The identification of the specific funds to meet the FY 90 National Guard requirements is to be accomplished during the upcoming budget review process when the specific funds to meet all Defense drug interdiction requirements will be identified.

QUESTIONS SUBMITTED BY SENATOR ROBERT C. BYRD

FY 1990 ARMY RECRUITING RESOURCES

Question: Recruiting is becoming more difficult for the Army and, to a lesser extent, for the Navy. Through the first half of FY 1989, 11 percent of Army recruits were in Mental Category IV (the lowest mental category accepted for military service by law), compared with only 4 percent in FY 1986-88. Both officials and recruiters in the field affirm that they are having to work much harder to obtain sufficient recruits and are accepting

people they would not have accepted in the past few years, even within existing guidelines. What resources is the Army committing in its FY 1990 budget to halt and reverse this declining recruit quality? In particular, are additional dollars budgeted for recruiting and advertising?

Answer: The Army is committing approximately \$610 million for recruiters, recruiting support, advertising, and enlistment incentives to achieve FY 1990 active enlisted recruitment goals and to set the stage for recruiting in FY 1991. This includes an increase in recruitment advertising of approximately \$10 million above the 1989 amount to improve awareness of Army opportunities. In addition, the Army, in conjunction with the Office of the Secretary of Defense, is promoting several legislative initiatives that will improve the Army's capability to attract quality personnel to critical shortage skills. This includes increasing the maximum Army College Fund (ACF) benefit from \$14,400 to \$25,200 raising the total educational benefit that the Army can offer--including the basic GI Bill benefits--to \$36,000 for a 4-year enlistment. Increasing the maximum amount that can be paid as an enlistment bonus is also under consideration. These initiatives should provide the Army with the capability to attract increased numbers of quality recruits to longer terms of enlistment and to skills that would otherwise be short of quality personnel. Removal of provisions in the Appropriations Act that restrict ACF benefits for 2-year enlistments to combat skills and prohibit combinations of enlistment bonuses and supplemental educational benefits adds to the Army's capability to attract adequate numbers of quality recruits. With this enhanced recruiting incentive flexibility and the recruiting resources requested, the Department believes it can achieve its FY 1990 recruitment goals cost effectively.

ARMY COLLEGE FUND FOR NONCOMBAT SKILLS

Question: Does the Army desire to reinstitute the two-year enlistment bonus for high-quality recruits in other than the combat arms, which appears to have been successful several years ago?

Answer: Yes, the Army believes that a large number of college-bound young men and women would be willing to delay their education and serve 2 years of active duty in a hard-to-fill noncombat skill if an Army College Fund (ACF) benefit were available. The Department of Defense believes that the Services should have the flexibility to

supplement basic GI Bill educational benefits for 2-year enlistments in noncombat skills on a case-by-case basis with approval of the Office of the Secretary of Defense. A Rand Corporation analysis indicates that the 2-year ACF incentive could be cost effective for certain noncombat skills if the enlistment contract also requires service for 2 years in a Selected Reserve unit. As a result, the Department requested congressional approval to test and determine the cost effectiveness of a 2-year ACF incentive for noncombat skills. The House and Senate Committees on Appropriations concurred with a 15-month test of this concept. While it is clear that we will be able to determine the supply expansion effect of this incentive following the test, cost effectiveness will not be known until the impact on reserve units can be assessed.

ARMY RESERVE COMPONENT RECRUITING RESOURCES

Question: Are there any indications that the quality of recruits with no prior military service for the Army Reserve and Army National Guard is also dropping? If so, has the Army budgeted money in FY 1990 for Guard and Reserve recruiting to deal with the problem? If not, why not?

Answer: In FY 1988, the Army Reserve and Army National Guard sustained the high quality of recruits achieved during the mid 1980s. Army National Guard accession quality improved slightly during the first half of FY 1989, partly due to a reduction in the numbers of non-prior service recruits when compared to the same period in FY 1988. The Army Reserve experienced a slight drop in quality over the same period. To achieve enlisted force recruitment goals for FY 1990, approximately \$191 million has been programmed for recruiters, recruiting support, advertising, and enlistment incentives for the Army Reserves and \$266 million for Army National Guard recruiting. Details of these budgeted amounts were provided to the staffs of the Committees on Appropriations. While Reserve components are experiencing increased difficulty in attracting quality non-prior service personnel, the budgeted amounts are considered sufficient to sustain the quality of the Army's reserve enlisted accessions.

EFFECT OF 8,000-SOLDIER REDUCTION

Question: How will the Army's recruiting requirements be affected by the 8,000-soldier reduction in the active

Army's strength proposed by the Administration for FY 1990?

Answer: The 8,000-soldier reduction resulted in a reduction of 4,000 accessions for FY 1989 and 4,000 accessions for FY 1990. These reductions will enable the Army to achieve its FY 1989 recruiting objectives although the Army may have to accept a higher percentage of AFQT Category IV personnel (7%) than in the previous three years (4%). The reduced FY 1990 mission still represents a 3 percent real increase in accession requirements over FY 1989. This increase and the requirement to rebuild the delayed entry program were considered in developing the Army's recruiting resource requirements for FY 1990 and FY 1991. These resource amounts combined with approval of legislation discussed in response to an earlier question are essential to achieve the quality recruiting goals of the Army.

QUESTION: The general thrust of both the Congress and the Executive Branch, as well as analysts out of Government, has been to cope with austere budgets over the past two years by cutting active duty, and adding to reserve component, manpower strength, and force structure. It has also been assumed that a large part of the massive reserve component force structure we have created, and, for the first time, attempted to train and equip adequately, over the past fifteen or so years would be required in the event of a NATO/Warsaw Pact war. Given that recent events in the Soviet Union and Eastern Europe indicate that both the intent and capability of the Soviet Union to attack NATO while maintaining a secure rear is much less than previously estimated, is it still justifiable to place more of our total force structure in the reserve components, where it is not available, without mobilization, to meet the Third World contingencies that we may have to cope with? Should we be reexamining our priorities for manpower and force structure so as to place more resources into our active forces, and less in the reserve components?

ANSWER: Our total force is developed to provide the national defense capability needed to counter the military threats to our national security. As these threats change, our national defense capability objectives change and thus our total force is adjusted. Consequently, our total force is constantly being fine tuned.

As the President's recent proposals indicate, events in the Soviet Union and Eastern Europe may make possible significant changes in our force structure devoted to the defense of NATO. If conventional forces reduction negotiations are successful and WARSAW Pact conventional forces are reduced, associated warning time will increase as a result of deactivation of active forces. This will diminish the

threat to NATO. This reduced threat should reduce U.S. forward deployment requirements which in turn will reduce our active component CONUS rotation base requirements.

As part of the Department's current review of our total force policy, we are reviewing carefully the national defense capabilities required to meet various possible third world contingencies. Part of this review involves refining the criteria for placement of functions in the active or reserve component. One criteria for placement of a function in the active component is when it is necessary for immediate deployment without reliance on voluntary or involuntary call-up of reserve component units or personnel. Application of this criteria may result in certain functions or part of certain functions being transferred from the reserve to active component.

Whether the active component will grow relative to the reserve component to meet potential third world contingencies is difficult to predict, since many other adjustments to our total force may occur as our national defense capability objectives change to meet changes in the military threats to our national interests.

MILITARY PAY RAISE IN FY 1990

QUESTION: Secretary Cheney has repeatedly stated that maintaining high personnel quality and readiness is his first priority. Yet he is funding only a 3.6 percent military pay raise in FY 1990--higher than some might have wanted, but lower than anticipated inflation rates. This comes at a time when recruiting and career retention, as noted above, are beginning to suffer. What would be the additional cost of a 4.6 or 5.0 percent pay raise? What would be the effects, as predicted by Department of Defense econometric models, of pay raises at these two percentages as compared with the requested 3.6 percent? Please provide a list of programs that you would select for cuts to pay for the pay raise, if the Congress directed a 4.6 or 5.0 percent pay raise.

ANSWER: The additional cost of a 4.6 or a 5.0 percent pay raise for FY 1990 would be \$507.5M and \$710.5M, respectively. The increased aggregate DoD force retention due to the two raises as compared to the requested 3.6 percent pay raise would be:

<u>Retention Increases</u>	<u>4.6%</u>	<u>5.0%</u>
*1st term (1-4)	3,138	4,508
*2nd term (5-10)	6,214	8,696
3rd term & beyond (11-30)	<u>10,453</u>	<u>16,778</u>
TOTAL	19,805	29,982

*In FY 1990, around 275,500 young men and women will be making a first or second term retention decision out of 891,000 individuals having 3-10 years of service.

The requested 3.6 percent increase does enable us to preserve the significant gains we have experienced in the past few years and is the level currently requested in the Defense Budget. It, however, falls short in our efforts to maintain the member's purchasing power in the market place and to close the pay comparability gap (currently -10.1 percent), primary factors in the retention decision. Therefore, the two proposals, both of which are comparable to the latest Consumer Price Index (CPI) and Employment Cost Index (ECI) figures probably would increase retention in the near term. The Department continues to believe, however, that the 3.6 percent increase is sufficient; in light of current budgetary constraints, we do not support any higher increase.

QUESTION: The Panel on Military Education of the House Armed Services Committee recently issued its final report, calling for better general quality, more jointness, and more rigor in officer professional military education (PME). Please describe the steps taken so far to bring PME into line with the Panel's recommendations. In particular, what is being done regarding the Panel's recommendations: (1) to create a National Center for Strategic Studies encompassing, but not limited to, the National War College and various institutes currently under the aegis of the National Defense University (NDU); and (2) to upgrade the curriculum and faculty of the Air University, which were severely criticized by the Panel's report?

ANSWER: There have been extensive measures taken to implement the Panel's recommendations, including significant re-design of joint curricula, student and faculty composition, and academic rigor at all of the Service colleges and the schools of the NDU. With respect to the two specific issues you raise, the creation of a National Center and the status of the Air University, there are actions going on now that will result in long-term benefits to both. The proposed National Center is a result of a concept forwarded by the Chairman, JCS, ADM Crowe. He has followed up on his proposal by chartering a National Defense University Transition Planning Committee, chaired by retired Navy Admiral Robert Long. This Committee is reviewing in depth the both the development of strategists in the Armed Services and the missions and functions of the NDU as a whole, including the appropriate and most effective means of creating a National Center out of the resources that currently exist within the NDU. Further, the Committee is examining the optimum role of both the National War College and the Industrial College of the Armed Forces in formulating national strategic direction. This Committee's review will be completed this Summer, and we will act on it immediately after the recommendations have been approved by the Secretary. The second issue you mention, that of the Air University, is also undergoing progressive review and restructuring.

The curriculum of both Air War and Air Command and Staff College have been significantly altered to improve academic rigor and increase "active" vice "passive" learning. The Air Force is also hosting a series of visits to the University by Congressman Skelton, Chairman of the PME Panel, keeping him personally advised of the schools' progress. These measures and others will improve the quality of Air University education in the long run.

The Department is continuing to work closely with the Joint Staff, the Services, and the schools to act on each of the Panel's many recommendations. Within resource limitations, we will continue to improve the quality, jointness, and military effectiveness of all our schools.

QUESTIONS SUBMITTED BY SENATOR DENNIS DeCONCINI

Career Opportunities for Women in the Armed Forces

QUESTION: Would you please define the "risk rule" and describe how it was developed by the Defense Department?

ANSWER: The DoD Risk Rule states, "Risks of direct combat, exposure to hostile fire, or capture are proper criteria for closing noncombat positions or units to women, when the type, degree, and duration of such risks are equal to or greater than the combat units with which they are normally associated within a given theater of operations. If the risk of noncombat units or positions is less than comparable to land, air, or sea combat units with which they are associated, then they should be open to women. Noncombat land units should be compared to combat land units, air to air, and so forth." The risk rule was developed by the Department of Defense Task Force on Women in the Military (September 1987 - January 1988). The Task Force found that the interpretation and application of the combat exclusion statutes generally have been left to the Service Secretaries and Military Departments. The statutes establish only minimum criteria for excluding women from military positions; namely, ships and aircraft with combat missions. Nothing in the law prohibited the Services from applying combat exclusion policies to units other than ships or aircraft, and all the Services have done so. The Task Force had several problems with the earlier "risk" interpretation of the law. First, it led to exclusion of women from noncombat positions or units that are not explicitly covered by the language of the statutes, thereby making such exclusions somewhat broader than the narrowest reading of the Secretary of Defense guidance. Second, since each Service had different risk thresholds, it led to inconsistent exclusions from one Service to another; that

is, similar positions or units in two or more Services that are open in one Service but closed in another. The new risk rule has become the norm for the Military Departments to review and evaluate noncombat support units and positions from which women were excluded. The Military Departments were directed to open those units and positions to women where the determination of "risk" was less than that of associated units within a given theater of operations. To date, more than 24,000 additional positions have been opened to women under the risk rule.

QUESTION: Would you assess what impact, if any, legislation introduced in previous Congresses to force the Department to expand opportunities for women had in the extensive review and ultimate decision to open the additional 24,000 positions?

ANSWER: Since February 1987, four bills were introduced before Congress which would have affected Department of Defense's and Services' policies concerning expansion of opportunities for women in the military. Although the bills did not directly lead to the decision to open the additional 24,000 positions to women, they were considered in the decision process. In summary, the bills were: (1) S. 581. A bill, "To amend title 10, United States Code, to increase the combat support assignments open to women in the Armed Forces." S. 581 seemed to be intended to open additional positions to women, without conflicting with current combat exclusion laws, by assuming that combat support jobs do not involve combat. The Department agreed that S.581 (which is based on function, not risk) would open additional positions to women in the combat support area, many of which would be located where engagement in combat situations is likely. However, the Department believed that the application of the risk rule, vice enactment of S.581, is a more rational approach for determining the opening of support positions to women and is in keeping with the intent of the combat exclusion laws; (2) H.R. 2719. A bill, "To amend title 10, United States Code, to increase the combat support assignments open to women in the Armed Forces." The House version of S. 581; (3) S. 1398. A bill, "To permit female members of the Air Force to receive fighter pilot training." Air Force Response: Federal law does not preclude women from being trained in fighter aircraft (10 USC, 8549, precludes women from being "...assigned to duty in aircraft engaged in combat missions"). For readiness reasons, the Air Force does not train aviators in combat weapon systems which they cannot fly in combat. In a wartime scenario, all combat aircraft and their crews could be needed for combat missions. Additionally, all other previously trained combat aircrews may be needed to account for attrition and rotational losses. Placement of noncombat aviators into fighter pilot training would significantly

impair our readiness capability and would not be cost effective; (4) H.R. 3798. A bill, "To direct a two-year test program under which female members of the Army, Navy, Marine Corps, and Air Force are assigned to combat support units, vessels, and aircraft." During testimony before the House Armed Services Subcommittee on Military Personnel and Compensation in February 1988, Representative Byron commented that the status of the proposed bill depended on the outcome of the implementation of the recommendations made by the DoD Task Force on Women in the Military.

CHILD CARE NEEDS

Question: Secretary Cheney has stated that recruitment and retention of qualified personnel is one of his top priorities in the Department. You stated that one of the greatest challenges facing the Department is the need for quality, affordable child care. You also estimate that 81,000 spaces are needed for children of military parents. Where are your greatest areas of need in this country? Is it a geographic need or one that is Service-based?

Answer: The need for expansion in child care is spread among all the Services and there are no specific geographic areas of need in this country. It can generally be said that the need is greatest in high-cost urban areas or at locations with large troop concentrations. In addition, a recent General Accounting Office study of child care in the continental United States revealed that although capacity in all Services is insufficient to meet demand, the Navy and Marine Corps seem to have the greatest need, as evidenced by the number of children on waiting lists.

DoDDS

Question: Your testimony indicates that there has been a significant increase in the student population at the Department of Defense Dependents Schools. It is my understanding, however, that a significant proportion of the students attending schools in certain areas are foreign nationals and not primarily American students. Would you provide me with a breakdown of U.S. students served by these schools versus foreign nationals and others? Are a large number of the American students studying at these schools children of State Department personnel or other private American business personnel? Has a burden-sharing system been explored for those schools at which a large proportion of the population is non-Defense Department related?

Answer: Overall DoD student population in DoDDS has increased, but overall tuition paying student population has decreased. All non-DoD students pay tuition.

While the number of students served by DoDDS has

increased over recent years, the number of foreign national students is on the decline.. From school year 1985-86 to 1988-89, the enrollment in schools increased from 149,821 to 151,778, an increase of nearly 2,000 students over a four-year period. During that same time, the number of foreign national students in schools decreased by 356 students, from 1,621 to 1,265. In 1985-86, the 1,621 foreign national students represented 1.1 percent of the total enrollment, whereas the current figure is only 0.84 percent. The number of students from government agencies, including the State Department, has declined by 20.5 percent, with 479 students in 1985-86 compared to 381 currently. The number of students with private American business sponsors has increased by 147 students (a 14.7 percent increase), with 999 students in 1985-86 compared to 1,146 students now. Students sponsored by foreign nationals, employees of Government agencies other than DoD and employees of private American business share the burden of costs by paying tuition to attend the schools. The tuition rates are set to recover the average cost of a student year of education. The total number of tuition-paying students in schools has dropped from 6,075 in 1985-86 to 5,010 currently.

Students are enrolled in DoD schools under one of four major tuition categories (definitions in attachment 1). About 95 percent of our enrollment are SPACE-REQUIRED TUITION-FREE related students, with one percent SPACE-REQUIRED TUITION-PAYING students, one percent SPACE-AVAILABLE TUITION-FREE students, and 3 percent SPACE-AVAILABLE TUITION-PAYING students as shown on attachment 2:

Attachment 1

- The SPACE-REQUIRED TUITION-FREE category includes 1) minor dependents of U.S. military personnel who have been transported to or from the overseas area or are authorized such transportation at government expense; and 2) minor dependents of U.S. government employees who are paid on a full-time basis from appropriated funds, entitled to a family living quarters allowance, stationed overseas on a transportation agreement, and are U.S. citizens or persons lawfully accorded the privilege of residing permanently in the U.S. as immigrants.
- The SPACE-REQUIRED TUITION-PAYING category includes: 1) minor dependents of DoD sponsors assigned to the Military Assistance Program; 2) minor dependents of DoD sponsors assigned to the Foreign Military Sales Program; and 3) minor dependents of foreign national citizens who were enrolled in schools operated by the former Canal Zone government on September 30, 1979, that were grandfathered under the treaty.
- The SPACE-AVAILABLE TUITION-FREE category includes: 1) minor dependents of DoD military sponsors who are stationed in an overseas area to which their dependents are not authorized transportation at U.S. government expense; 2) minor dependents of DoD civilian sponsors who work full-time, are paid from appropriated funds, and who are not entitled to a living quarters allowance; 3) minor dependents of other sponsors when a waiver of tuition costs has been granted by the Secretary of Defense.
- The SPACE-AVAILABLE TUITION-PAYING category covers two groups. The Federally connected group includes: 1) minor dependents of U.S. government employees (including those covered by an Economy Act agreement between their agencies and DoD, as well as those of DoD non-appropriated fund instrumentalities), provided employees are U.S. citizens or persons lawfully accorded the privilege of permanently residing in the U.S., are entitled to living quarters allowances, or have been identified by their agencies as being eligible for educational benefits on a tuition-paying basis; 2) minor dependents of U.S. citizens and employees of entities overseas which serve significant defense-related interests or which have executed contracts with the U.S. government which authorize dependent education in DoD dependents schools on a tuition-paying basis; and 3) minor dependents of host nation or third-country national military or civilian personnel assigned or attached with U.S. military services overseas at international or major DoD commands when recommended by the major overseas commander. The non-federally connected group includes: 1) minor dependents of other U.S. citizens, and 2) minor dependents of foreign nationals whose enrollment may have been determined to be in the national interest by the Secretary of Defense.

Attachment 2

	<u>SCHOOL YEAR 1985-1986</u>		<u>SCHOOL YEAR 1988-1989</u>	
	STUDENTS	% OF TOTAL	STUDENTS	% OF TOTAL
SPACE-REQUIRED TUITION-FREE	141,386	94.70%	144,472	95.55%
SPACE-REQUIRED TUITION-PAYING	1,527	1.02%	964	0.64%
SPACE-AVAILABLE TUITION-FREE	1,836	1.23%	1,702	1.13%
SPACE-AVAILABLE TUITION-PAYING	4,548	3.05%	4,046	2.68%
GRAND TOTAL *	149,297	100.00%	151,184	100.00%

* EXCLUDES PANAMA CANAL COLLEGE ENROLLMENT

QUESTIONS SUBMITTED BY SENATOR ROBERT W. KASTEN, JR.

TRAINING FOR CATEGORY IV RECRUITS

Question: For the first half of FY 89, Category IV enlistees comprised 11 percent of the total recruits. I understand that this trend is expected to continue. What adjustments in training practices will the Armed Forces have to make to compensate for this trend?

Answer: For clarification, the proportion of Category IV non-prior service enlistees in the first half of FY 1989 was 11 percent for the Army, but only 7 percent for the Department of Defense as a whole. Furthermore, current projections indicate that the Category IV proportions for the entire fiscal year will be lower, approximately 7 percent for the Army and 5 percent for the Department of Defense.

Service training programs are designed to accommodate some Category IVs. With up to about 10 percent Category IVs, probably no significant adjustments in training methods would be required. With higher percentages of Category IVs we could expect higher attrition rates and, for some slow learners, the need to repeat portions of courses. More individual attention would have to be paid to recruits who were having difficulty in absorbing the instruction. Beyond these actions, we would not anticipate having to change teaching methodologies appreciably unless the proportion of low-aptitude recruits rose to levels significantly higher than we now anticipate.

ATTRACTING HIGH QUALITY RECRUITS

Question: What can the Armed Forces do to attract a higher percentage of recruits in the Category 3 and higher range?

Answer: To sustain adequate recruit quality, the Armed Forces must remain competitive in the youth labor market. This means that the military way of life must be perceived as desirable and that military pay is equitable. While more than 90 percent of current recruits score in AFQT Category III or higher (compared with 69 percent of the youth population), we have experienced some growth in the proportion of enlistments in AFQT Category IV in recent months, and want to arrest this trend. Working with Congress, we must ensure that sufficient numbers of recruiters, recruiter support resources (such as office facilities, telecommunications, vehicles, etc.), advertising, and competitive enlistment incentives

are available. These resources help ensure that prospective enlistees are contacted, informed of available military opportunities, and provided a chance to enlist. The recruiting resources requested in the FY 1990-91 budget, coupled with legislative initiatives described earlier, should provide what we need to assure adequate recruit quality.

SUBCOMMITTEE RECESS

Senator INOUE. The subcommittee will stand in recess until 9 a.m., Tuesday, June 13. At that time, we will discuss strategic programs.

[Whereupon, at 10:15 a.m., Thursday, June 8, the hearing was recessed to reconvene at the call of the Chair.]

DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 1990

TUESDAY, MARCH 14, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:35 a.m. in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Lautenberg, Harkin, Stevens, and Specter.

DEPARTMENT OF DEFENSE

ENLISTED PERSONNEL ISSUES

OPENING REMARKS OF SENATOR INOUE

Senator INOUE. The subcommittee will come to order. This morning, the Subcommittee on Defense Appropriations will hear from the senior enlisted members of the four military services, and on behalf of the committee I wish to welcome Sergeant Major of the Army Julius W. Gates; the Master Chief Petty Officer of the Navy, Duane R. Bushey; the Chief Master Sergeant of the Air Force, James C. Binnicker; and the Sergeant Major of the Marine Corps, David W. Sommers.

In addition, we have invited Ms. Sydney Hickey, director of government relations of the National Military Family Association, and Sgt. Maj. C.A. (Mack) McKinney, legislative counsel of the Noncommissioned Officers Association of the United States of America, to address issues of importance to enlisted members of the services. Both Ms. Hickey and Mr. McKinney have appeared before the committee in years past and we are glad to have them with us again today.

Our most important defense resources are not sophisticated weapon systems, but rather the men and women who serve in the Armed Forces. Out of a total strength of 2.1 million active duty personnel, 85 percent are enlisted personnel. They are the backbone of our Nation's defense. Someone once said that there are only two ranks of any consequence in the services: General and sergeant, and that the sergeants really run the show. As a former sergeant myself I fully agree. [Laughter.]

QUALITY OF LIFE/FAMILY

Gentlemen, during your careers you have seen the military change from a largely conscript force to all-volunteer, with all the differences that implies.

Twenty-five years ago, little or no emphasis was placed on family issues such as child care, single parents, and spousal employment, or spousal and child abuse. Today, these issues and others like them are paramount in retaining a seasoned, experienced force and we will be most interested in your comments on these matters.

I cannot help but recall, at the stage that I was in the service—that is eons ago—about 5 percent of the men had dependents and I believe in the Marines today that 60 percent have dependents, and it must be the same across for all the services.

We are glad to have you here with us today. I think we will let each of you make a statement and you can do so in any fashion that you wish. All of your prepared statements have been made a part of the record. You may give it in total or you may summarize it, or present it in any way you wish, sir.

We would like to begin with Sergeant Major Gates.

STATEMENT OF SERGEANT MAJOR OF THE ARMY JULIUS W. GATES, U.S. ARMY

Sergeant Major GATES. Mr. Chairman, committee members, good morning. It certainly is a great day in our Nation's Capital. I am honored to be given this unique opportunity to address you on behalf of our great soldiers of the total United States Army.

Today we do have a quality Army. Through your continued support and concern we are improving the quality of life for our soldiers and their families. Your soldiers of today have a winning spirit that is certainly contagious. I would like to point out for you some areas where we believe that winning spirit is very evident.

Last year, your soldiers serving in West Germany took first and second place in the Boeselager Cup Competition, a tough 4-day field exercise that tests the very best armored cavalry teams within the entire NATO. Your soldiers won first and second place.

SUMMER OLYMPIC PARTICIPATION

Eighteen of your soldiers participated in the 1988 Summer Olympic Games that were conducted in Seoul, Korea. They brought home four medals—three gold and one silver. And about 4,000 of your soldiers helped fight the forest fires in our Yellowstone National Park last year.

Ladies and gentlemen, if it sounds like I am bragging a bit about our fine soldiers, then I am relaying the right message to you. These are only a few of the many examples of our winning spirit today.

During the last 6 months I have had the opportunity to talk at canteen cup level with leaders, soldiers, and family members in Germany, the Pacific, Central America, and at numerous camps, posts, and stations throughout the continental United States, to include the Active Force, National Guard, U.S. Army Reserves, and our retired alumni.

Your soldiers are concerned. We have come a long way from the Army of the 1970's. We strongly believe that our Army and our country cannot afford to allow any trend to develop that will cause us to lose our winning spirit. Your Army is only as good as the soldiers who fill the ranks.

The major issues of concern for the enlisted soldiers are: medical care, especially medical care for their dependents; pay and allowances that are competitive with the civilian sector; affordable housing regardless of their duty station; and a predictable future. I have covered these areas in my statement for the record in detail.

RECRUITING/RETENTION

We also are concerned about our ability to recruit and retain quality soldiers. The majority of our recruiting force are noncommissioned officers who are detailed from our TO&E and TDA units. We select these outstanding soldiers, we train them, and we expect and demand they recruit quality soldiers and men and women into our Army.

They are required to accomplish that objective in competition with the lowest national unemployment in more than 14 years and the highest youth wages in recent history. We do not supply these great soldiers with the necessary tools to be successful in their recruiting environment.

The lack of enlistment incentives causes some of these great NCO's to fail in their recruiting mission. To assist these noncommissioned officers and to maintain our momentum we must have additional enlistment incentives, such as the authority to test the Army college fund incentive for combat service support enlistments.

Over the years we have been successful in retaining many of our high quality soldiers because of our leadership and challenging training. Many of these high-quality soldiers are now entering the junior noncommissioned officers ranks. In addition, we have been able to target selected reenlistment bonuses to soldiers that have been trained in critical military occupational specialties.

The leaders across the Army inform me that recent changes in resources for tough, realistic, challenging training, combined with no increases in resources for selective reenlistment bonuses have, and continue to have, an effect on our ability to retain a quality Army.

MORALE, WELFARE, AND RECREATION

Another area is in the area of morale, welfare, and recreation. This year, due to unexpected increases in transportation cost and continuing currency fluctuations, the imposed cap on appropriated funds for MWR will cause us to be short of funds to meet our obligations unless we can find some relief. The added cost will eventually be passed on to our soldiers and their families. The losers again will be our soldiers.

If we are to avoid a decline in the quality of our soldiers and the overall quality of our Army, we strongly believe that we must have additional enlistment and reenlistment incentives to compensate for the changing environment. We must provide our soldiers, both

single and married, with affordable, adequate housing, and we must provide our soldiers and their families with top medical care. We must provide wages that are competitive with the civilian sector and we must maintain affordable morale, welfare and recreation activities and facilities. Probably the most critical is, we must provide our soldiers with a predictable future based on promotions, benefits, and a retirement system that is fair and consistent.

There are many other soldier issues that deserve your attention. However, I have covered the major concerns. While you make the hard decisions that are facing our country, I know that you will do what is right for our soldiers. Rest assured, our soldiers will do what is right for our country when needed.

Sir, that concludes my remarks. I will be glad to answer your questions.

Senator INOUE. Sergeant Major, I thank you very much. We will listen to the panel first and then we will proceed with the questions.

[The statement follows:]

STATEMENT OF SERGEANT MAJOR OF THE ARMY JULIUS W. GATES

Mr. Chairman and Committee Members, I am honored to be given this unique opportunity to address you on behalf of our great soldiers of the total United States Army.

QUALITY ARMY

Today, we have a quality Army. We have quality training, quality equipment, quality leadership, and we have the best men and women from our society serving in our ranks. We appreciate your support for the much needed PCS weight allowance increase, the 4.1 percent basic pay increase, and the basic allowance for quarters increase. Through your continued support and concern we are improving the quality of life for our soldiers and their families. Your soldiers have a winning spirit in our Army of today that is contagious.

Our challenge is to recruit, train, equip, and retain a quality Army. However, there appear to be some clouds forming on the horizon that have, and will, affect our ability to meet the challenge.

SOLDIER CONCERNS

During the past six months I have had the opportunity to talk at "canteen cup" level with leaders, soldiers, and family members in Germany, the Pacific, Central America, and at numerous camps, posts, and stations throughout CONUS, to include the Active Force, the National Guard, U.S. Army Reserve, and our retired alumni. Your soldiers are concerned.

The major issues of concern for the enlisted soldiers are:

- Medical care
- Pay and allowances
- Housing
- A predictable future

MEDICAL CARE

The availability of medical care for family members and retirees continues to be the major quality of life issue. Many soldiers are required to pay out of pocket expenses for medical care under the CHAMPUS program. And while our medical personnel provide excellent care we continue to have problems with staffing our existing facilities and providing adequate facilities to meet the patient demand.

Medical care for families is a key factor in retaining soldiers in our Army. They want to be assured that their family members will have medical care available regardless of duty assignment and they want to know what will be available for them and their family members at retirement. The proposed user fee for dependents at military facilities is considered as another lost benefit and adds to soldiers frustrations in their ability to provide adequate medical care for their families.

The dental plan, the primary medical care program, and the ongoing Army actions to improve care at Army facilities are all welcome initiatives. We strongly solicit your support in this area. Soldiers and their family members deserve quality medical care.

PAY AND ALLOWANCES

Why is a military pay raise needed? This year about 4.5 million dollars of Federal food stamps and about 2 million dollars of Women, Infant, and Children coupons were redeemed by soldiers at CONUS Army commissaries. We have soldiers whose standard of living is below the national poverty level.

Our soldiers know their pay has not kept pace with either their civilian counterparts or inflation. The comparability gap stands at 10.1 percent and pay lags inflation by 1.2 percent. Our soldiers want and desire a system upon which they can depend for fair and competitive raises which will allow them an adequate standard of living.

The 3.6 pay raise contained in the President's Budget is a necessity. Anything less will further damage our soldiers purchasing power and their standard of living. In addition, it will send a clear signal that their service to their country is not valued.

HOUSING

The lack of adequate on post housing or affordable economy housing, and the allowance system are major contributing factors that cause some of our quality soldiers to live below the national poverty level.

New construction and the build to lease program have greatly assisted our housing problems. However, we still have a valid need for additional housing. The average family housing unit is almost 34 years old and in need of maintenance and repair. Our resources fall short of this need. The result is inadequate and deteriorating family housing units which impact on morale and retention.

Soldiers deserve a total housing allowance which allows them to obtain suitable accommodations regardless of duty station. Because the basic allowance for quarters is not adequate to cover normal housing expenses or the actual cost of living in most areas of the United States. A Variable Housing Allowance supplements the Basic Allowance for Quarters. However, an imposed ceiling on the annual amount of funds available for Variable Housing Allowance prevents the housing allowance system from operating as it was intended. Therefore, soldiers must bear an unacceptably high percentage of housing costs. Removal of the Variable Housing Allowance ceiling is essential if we are to provide an adequate housing allowance to all our soldiers.

Since 1981 we have constructed some of the most modern barracks available for our bachelor soldiers. However, we still have thousands of bachelor soldiers who are required to live in World War I, World War II style barracks in Germany and quonset huts in Korea. Many of these barracks are overcrowded with inadequate heat and bath facilities.

Soldiers form a lasting negative impression of our Army because they are forced to live under these conditions. We will not be able to retain these quality young Americans in our Army if we can't fix this problem. I respectfully ask for your help in this area.

PREDICTABLE FUTURE

A leader should be able to sit down with a soldier and assist the soldier in planning his/her future in the Army. It is a tough task to accomplish because of the uncertainties. Two of the basic ingredients of career planning are predictions for promotions and retirement benefits. Shortages in funds for the military personnel account forced us to reduce the NCO inventory resulting in anticipated shortages of about 14,000 NCO's in FY90. We demand excellence from our soldiers, however, we are not able to reward these soldiers with deserved and earned promotions. The retirement system has been repeatedly modified over the past ten years—always downward. Soldiers want a system upon which they can plan their futures. They need to be able to tell their families that after retirement they will have a retirement check that will maintain its full value. They need to know that after spending most of their adult life in the Army that their standard of living will not decrease each year.

CONCLUDING STATEMENT

All of these and other quality of life issues raised by soldiers significantly impact on recruiting and retaining a quality Army.

In addition, we are faced with a recruiting challenge. Our recruiting force is competing with the lowest national unemployment level in more than 14 years and the highest youth wages in recent history. Meanwhile, Army incentive and recruiting resources have been cut significantly.

If we are to avoid a decline in the quality of our force, we must have additional enlistment programs and an attractive living environment. We need to lift the restriction on the use of the Army College Fund incentive for non-combat arms specialties. We must be able to target selective reenlistment bonuses against critical Military Occupational Specialties. We must be able to provide wages competitive with the civilian sector. We must be able to promote deserving soldiers and, because our Army today is a married Army, we must continue programs to support our family members.

There are many other soldier issues that deserve your attention. However, I have covered the major concerns. While you make the hard decisions that are facing our country I know that you will do what is right for our soldiers. Rest assured our soldiers will do what is right for our country, when needed.

STATEMENT OF MASTER CHIEF PETTY OFFICER D. R. BUSHEY, MASTER CHIEF PETTY OFFICER OF THE NAVY

Senator INOUE. Our next witness will be Duane R. Bushey, the Master Chief Petty Officer of the Navy.

Chief BUSHEY. Good morning, Mr. Chairman. Thank you for your kind remarks in opening, and apparently I have been reading the wrong books. I heard there were two ranks: admiral and chief. [Laughter.]

Senator INOUE. Correction noted, sir. [Laughter.]

Chief BUSHEY. Thank you, sir. Quality of life for sailors is a complicated issue. For the married sailor it revolves around the family, housing, child care, and medical needs, but more importantly, more time at home with our families.

Yet if we are not careful just the opposite will happen. God has not taken any oceans away from us. Our Commander-in-Chief has not taken any missions away from us, and if we keep the same worldwide commitment with a shrinking pool of manpower we will have to spend more time at sea.

Family separation continues to be the No. 1 dissatisfier in our surveys. It is the No. 1 reason people leave the U.S. Navy. We must balance the proper amount of time at sea and time at home, as well as establish a support network to make family separation more palatable.

My wife, who is here with me today—and I have enjoyed 25 years of marriage and 26 years in the Navy. It has not always been easy but I think we are headed in the right direction on how we take care of our families today.

Also, let us not forget our single sailors. They like to travel and have adventure and they do cherish quality time at home. There is no place like the United States of America. While in home port our single sailors need to be able to live in a manner conducive to good morale and good health. The quality of a command's morale, welfare, and recreation programs can be directly linked to the unit morale and conduct of our sailors ashore and our retention. It is a proven fact that people will act in the manner in which you treat them.

ENLISTED QUARTERS

Enlisted quarters are in short supply and existing enlisted quarters must be upgraded in order to promote the above-average standard of behavior expected of our young sailors today. I believe this will help lead the Nation.

We have helped build the Nation a Navy to be proud of. Our sailors are respected in their communities. They tutor young people in our school systems. They support community programs and they support city officials. They set the proper example. They get involved. They are taxpayers and they are voters.

Our enlisted personnel realize their share in solving the national deficit, but we also realize that the Navy must maintain the quality level the Nation has spent so much money to get us to. Our most important asset is our people. We say this over and over again, yet we are 10.3 percent behind the civilian sector in pay. Our training and our quality of life programs fight bloody battles against the already too small operational budget.

While we are not asking for more than our fair share, we are proud to serve our country, to go in harm's way when necessary. We are proud to be ambassadors in foreign countries. We serve our communities at home and support the policies of our Commander-in-Chief. We look forward to working with you this year and look forward to your support.

I am prepared to answer your questions, sir.

Senator INOUE. Thank you very much.

[The statement follows:]

STATEMENT OF MASTER CHIEF AVIONICS TECHNICIAN (AIR WARFARE) DUANE R. BUSHEY, MASTER CHIEF PETTY OFFICER OF THE NAVY

INTRODUCTION/OVERVIEW

Mr. Chairman and distinguished members of the Subcommittee, I am privileged to appear before you in my capacity as the Master Chief Petty Officer of the Navy to present my testimony on Enlisted Personnel Issues affecting Navy personnel.

My statement presents the enlisted views on those considerations which constitute "Personnel Issues." I would like to begin with an overview of those observations.

The quality of naval enlisted personnel has never been better. Morale is good and the enlisted sailors serving in today's Navy feel a sense of need as well as a sense of accomplishment. However, in my travels and candid and private talks with sailors, I get a strong feeling that we have a lot of "fence walkers" when it comes to an individuals' decision to reenlist. Most sailors are very proud to serve their country and to wear the uniform of the United States Navy. They willingly sacrifice a piece of their own freedom and honorably serve to preserve democracy; but at the same time they have a very strong urge to live equal to their civilian counterparts.

The modern sailor is a volunteer professional and very much a part of the community in which he or she lives. Gone are the days of "drunk as a sailor, or "spend money like a sailor." Today's sailor shows a positive involvement in the community and sets the pace for society. The Navy tackles the tough issues, solves them, and assists in setting the course for the nation.

"Zero tolerance" on drugs, responsible use of alcohol, child care and equal opportunity are a few issues that the Navy has leapt forward with and shared with local communities and the nation.

The modern sailor is politically aware and wise. They pay taxes, vote, and follow current political events and political stands. They know and respond to the votes of support and also lack of support from their congressional representatives as never before, which brings us to why I am here today.

Earlier, I said we have many "fence walkers." Many of the sailors serving our country feel that the military is losing favor with our legislatures. The signal they

get is that benefits will erode below tolerable levels; pay raises ironically, are resulting in reduced take-home-pay to some—the troops know we are 10 percent below the civilian sector in pay and barely maintaining our own; and after-service benefits are perceived to be eroding. In addition, medical care is not adequate with talk that they will have to pay for their health care. There is also the constant attack on the retirement plan—all when unemployment is at five percent in the civilian community where there are equally paying jobs, better medical and dental plans and where many corporations make available decent child care.

I strongly believe that retention is as good as it is today only because of positive leadership within the senior ranks of the Navy. Job satisfaction too, is a contributing factor to retention—tools, equipment and parts are pretty much available for the sailors to be able to complete their tasks with a sense of pride and professionalism. We've been able to maintain adequate manning at sea; but at the cost of undermanning on shore; which is creating long work hours and taking away the palatability we need for a volunteer force.

I do want to thank the Congress for the good signals we've recently had—we're okay in permanent change of station (PCS) monies for this fiscal year, we received a much needed increase in PCS weight allowance, and we appreciate your support for a 4.1 percent pay increase. However, we need your continued support in areas of critical concern to the sailors in the fleet today in those areas which constitute their quality of life.

II. COMPENSATION

A. Basic Pay. We are not looking for superiority over our civilian counterparts; we are seeking comparability. Though, even at equitable pay standards, sailors endure a multitude of hardships not encountered in the civilian sector. Our sailors suffer long family separations, average longer work-days both at sea and on shore, and spend more time in harms way than their civilian counterparts. A growing percentage are having to maintain separate households because they can't afford to have their families living with them in the high cost-of-living areas where they are homeported. The fiscal year-90 proposed pay raise of 3.6 across the board is the bare minimum we should consider to be acceptable. Another pay cap will only increase the disparity between military and private sector wage levels and provide incentive for the Navy's best and brightest to seek employment elsewhere.

B. Basic Allowance for Quarters (BAQ) and Variable Housing Allowance (VHA). The housing allowance system, as amended in fiscal year 1985, has three components. They are Basic Allowance for Quarters (BAQ), Variable Housing Allowance (VHA) and an out-of-pocket contribution equal to 15 percent of national median housing cost which equates to 23 percent of BAQ. BAQ is supposed to be maintained at 65 percent of the national median housing cost of service members by pay grade. These percentages were established in the fiscal year 1985 VHA revision. Fifteen percent out-of-pocket expense is reasonable. However, we are now approaching 22 percent by current figures, and we believe in many areas it is much higher. San Diego, Long Beach and Port Hueneme, California; Earle, New Jersey; Groton, Connecticut; New York City; and other places where I hear sailors begging for some monetary relief. Many junior enlisted personnel have stated that their entire paycheck goes for housing. Their spouse has to work just to buy essentials; also more often than not this brings with it the added expense of child care costs and what's left over may pay the food bill, but what about the electricity, telephone, car payments and car insurance? So many of our sailors are forced to live in slums, high crime areas or commute 40 to 80 miles a day in order to get adequate, affordable housing—with the added burden of reliable transportation or transportation costs. Many live on a shoe string and any minor, unexpected expense puts them in extreme financial difficulty. Bankruptcies and letters of indebtedness have increased and many supervisors complain about lost work time because their sailors spend time in financial counseling. Many of our junior enlisteds can't afford to save for a rainy day let alone put something aside for their children's education. Poverty breeds poverty. To maintain the quality of life factor that decent housing represents to our sailors, particularly our junior personnel, we need to repeal the VHA offset, drop the VHA cap, and increase BAQ rates. The goal must be to return service-members' out-of-pocket costs to the average 15 percent of national median housing cost by pay grade intended by the current VA program.

C. Cost of Living Allowance (COLA). Good international relations is a very important part of our Navy mission when sailors and their families are stationed overseas. It is not reasonable to expect them to limit all their activities overseas to the confines of a military base. In Japan, for example, a simple stop at a fast-food res-

restaurant for a good ol' "American" hamburger—a taste of home—can cost up to \$10.00 a person; a short mass transit ride from Yokosuka to Tokyo is a \$37.50 outing for a family of four, just for transportation. A trip to a near-by park in Atsugi costs \$13 in tolls. Daily transportation from Navy housing to the base at Yokosuka is \$10 round trip. Yet surveys will indicate Cost of Living Allowance (COLA) should be cut. It's a "catch 22:" the lag in COLA drove our Navy families to limit their activities to on-base entertainment. Those costs, or rather lack of costs, are reflected on COLA surveys which, in turn, drive COLA's further down.

D. Bonuses. The Selective Reenlistment Bonus (SRB) program is the "bread and butter" of the Navy's retention efforts. The payment of SRB's, our most critically manned specialties is both prudent personnel management and cost effective. For instance, we invest approximately \$62,000 in training a nuclear plant operator. To retain that trained individual we pay a maximum \$30,000 SRB. This comparison illustrates the savings in retaining an experienced operator versus the cost of having to start from scratch training a replacement. It must be pointed out that the savings illustrated above does not take into account the \$2,800 we spend recruiting the person to be trained or the lack of productivity while in their qualification process. Enlisted bonuses have proven extremely effective in the competitive recruiting environment when endeavoring to attract those top quality personnel we need to man the technically sophisticated Navy of today. We need continued Congressional support for these essential programs.

III. HOUSING

The availability of adequate and affordable housing is at a critical point. We have a 55,000 housing unit shortage world-wide—38,000 in the E-4 to E-9 community. The Navy is located primarily on the water front where two extremes are found: the affluent section and slums. The first one we can't afford financially; the other puts our Navy families in danger because our families find that inadequate housing in high crime areas is the only affordable alternative to family separation. If not in the slums, many of our families drive 70 to 80 miles a day over excessively congested highways to find affordable housing in secure areas like the San Francisco Bay area. In addition, many are opting to be geographical bachelors and that has a negative impact on morale. Case in point: a first class petty officer who has been stationed 4 years in San Diego, found a comfortable neighborhood and is maintaining affordable rent. His wife has a good paying job and child care has been well established. They cannot afford nor are willing to make the tremendous sacrifice of another move. The sailor received orders to San Francisco and is now a once-a-month visitor to his family and is just biding his time until his current enlistment is up. The Navy is losing a lot of valuable experience and costly training. It is unreasonable to ask our people to make these sacrifices. As housing costs soar and allowances remain static, the result is a decreased quality of life for our sailors and added costs to retrain sailors to keep the fleet at a viable state of readiness. The most severe impact of the nonavailability of Military Family Housing (MFH) is felt by our junior enlisted personnel. We need the continued support of the Congress and particularly this subcommittee in solving this problem. We need your assistance in aggressively pursuing funding of MFH Military Construction projects and the continued support for initiatives such as Section 801 Housing and Third Party Financing in order to provide more adequate and affordable housing for our people.

IV. BACHELOR ENLISTED QUARTERS

Single housing is just as critical as family housing. Living aboard a ship can best be described as cramped, total lack of privacy, claustrophobic, continual compromises, noise, varied work schedules, no day or night—just 24 hours continuous. Music and television must be shared. There is no walking to the refrigerator to satisfy a late afternoon or midnight hunger, nor can you go anywhere for a moment of peace. Many of you have visited our ships at sea, how many of you have spent a night in enlisted berthing though? Try it. We accept the lack of privacy and lack of normal comfort that is inherent with ship board living. In fact, major habitability improvements have been achieved with our modern ships. However, when long awaited shore duty becomes available for our single sailor, they expect living standards to improve. Often this does not happen. Substandard World War II barracks, inadequate communal heads, poorly designed and maintained heating and air conditioning (if any) is what they find. Many of our personnel would opt to live off base but find that apartments are not available or even affordable. Life back home begins to look much more comfortable, and so does the job market, the pay, and the

freedom. The obvious happens; retention suffers. Improved billeting ashore for our single sailors is a must in the scheme of quality of life.

V. PERMANENT CHANGE OF STATION (PCS)

Increased weight allowances, improved permanent change of station (PCS) funding, per diem and dislocation allowances, extended pay-back on advanced pay have all been favorable steps toward making PCS moves more tolerable within the continental United States. However, overseas moves remain extremely difficult. When a sailor transfers overseas, he or she has to establish a residence on the local economy in many of the areas the Navy serves. In Europe and Japan especially, these moves require up-front money the first month anywhere from \$3,000 to \$5,000. This doesn't even include many of the familiar items we as Americans are accustomed to having such as heating, air conditioning, lights, closets and fixtures. In Japan, American automobiles are prohibited and if a sailor has just purchased an automobile prior to receiving orders, they are faced with a choice of either selling at a loss, or putting it in storage state-side for 2 to 4 years at their own expense while still making car payments. And once in Japan, it becomes a necessity to purchase another car there, plus be confronted with the mandatory 2 year off base insurance. At this point, it's hard to visualize the rewarding experience being stationed overseas offers. We must find ways to alleviate the emotional turmoil this financial strain puts on our enlisted sailors.

VI. MEDICAL CARE

The availability of medical care for spouses and children continues to be one of the major quality of life issues in the Navy today. Many personnel are being required to pay out of pocket expenses for medical care under the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program to compensate for the lack of medical care for dependents and retirees at many Navy medical facilities. This is an uncompensated expense that most personnel cannot afford and adversely impacts on the overall compensation package. That members may have to pay user fees for dependents at military treatment facilities is viewed by service members as an erosion of a benefit which is essential to the peace of mind of those who go to sea for extended periods of time. Establishing Navy Primary Medical Care Clinics (NAVCARE) has alleviated some problems and CHAMPUS Prime has been a big relief in California. The actions of Congress to improve the availability of direct health care to this point are appreciated, however, much more needs to be done. The military medical system must be able to provide quality care for all beneficiaries. Until affordable alternative medical care is in place, this issue will continue to have a negative impact on quality of life.

VII. RECRUITING

In my interviews with many of our enlisted recruiters, they feel an already difficult job is made even more difficult by a lack of financial support in recruiting. Most high school students do not understand the mission of the Navy, nor do they realize the technical aspect available to sailors. Being a sailor is viewed as a very lonesome, unskilled drudgery; not as an exciting, rewarding profession. Money is not funded in sufficient amounts to educate the public on Navy-specific adventure. We have been getting good quality people, but we must continue this trend if we are to meet the needs of an increasingly complex Navy facing an increasingly complex threat around the world. The pool of recruitable high quality male high school graduates is shrinking and highly sought after by civilian employers and institutions of higher learning. We must redouble our recruiting efforts to ensure that we do not fail to attract the best and brightest to serve in the Navy. We need also to look at the hardships facing our recruiters. Navy recruiters are allowed to claim reimbursement for incidental expenses up to \$60.00 per month. With proper justification and documentation, local commanding officers are authorized to pay reimbursements exceeding that \$60.00. However, with the reduced recruiting funding this year, district levels have less operating targets and it seems reimbursing the recruiter's out-of-pocket expenses is one area that has been tightened up. We must support our recruiters by providing them with the assets necessary to ease these additional burdens. Your support for both recruiting and recruiting advertising dollars is essential to meet our challenge of satisfying Navy requirements for quality recruits in competing with educational institutions and civilian industry, both of whom are looking for quality men and women.

VIII. FAMILY SUPPORT

Navy Family Support Centers have proven their value in supporting our Navy family; singles and married, active duty and dependents. We must ensure and support proper funding and quality management of these centers.

A. Child Care. Child care and child development are a national problem that impacts even more severely on the military community. Great strides have been made, but much more must be done. When I meet with a group of sailors, the primary concerns are child care and housing. The demands for child care have become more critical because of a number of reasons: both parents must work to make ends meet, the number of military married to military is on the increase, and the number of single parents in the military is on the upswing. The burden of child care is much more severe for sailors because of sea duty, watch standing, shift work, and long working hours because of undermanning ashore.

The availability of child care facilities is a critical quality of life issue. The Navy has approved home day care in housing areas at some commands which serve children who otherwise would be added to the long lists awaiting space in day care facilities. Program expansion has been hampered by the lack of personnel to properly monitor the homes. Imposed funding constraints have further slowed our progress in hiring qualified home day care monitors. Most child care centers have waiting lists of several hundred children and many operate too few hours to adequately meet military parents' work schedules. The shortfall is primarily driven by many old and substandard structures and the inability to attract and retain staff because of low salaries. Some of the families living on the local economy are in dire financial straits and in some cases are unable even to afford the cost of military-subsidized childcare. To help us meet this critical need, we ask Congress to approve our fiscal year 1990 budget request for additional military construction funds for child development projects.

IX. MORALE, WELFARE AND RECREATION (MWR)

Morale, Welfare, and Recreation (MWR) programs are vital to the good mental and physical health of our sailors; especially our young, single sailors living aboard ship and in the barracks. Gymnasiums, swimming pools, hand ball courts, and entertainment programs are regarded as an earned benefit. Any reduction of these services or added cost to an individual sends a very strong and negative, however false, signal to our sailors that the Congress has a total lack of appreciation for the sacrifices sailors make to serve their country. Our club system is very important and it is absolutely essential overseas. Due to recent extensive appropriated fund (APF) changes, cuts, and caps, the Navy is actively adjusting its MWR operations and funding approaches. The Navy has made drastic improvements in some localities in bringing the club system up to providing a modern-day, customer-responsive system which is self-supporting.

X. SUMMARY

We must not repeat the drastic personnel actions we were forced to take in fiscal year 1988 because of significant shortfalls in funding; delaying enlisted advancements, increasing time-in-rate requirements for E-1/E-2 personnel, establishing a voluntary/involuntary early release program, extending all tours by 2 to 4 months, reducing Special Duty Assignment pay, and delaying start-up of Selective Reenlistment Bonus (SRB) program—then releasing new award levels late. Our men and women continue to perform at top levels. Readiness and esprit de corps remain high. Our sailors realize their obligations to contribute their fair share to budget reduction, and as I said earlier, our sailors are smart, they are learned, and they are aware of political issues and congressional stands. But when their ability to provide an adequate and secure standard of living for their families is threatened, retention eventually suffers. The downward trend in retention is of concern and must be reversed because retention is directly attributed to how compensation issues are handled. I fully appreciate the difficulties this subcommittee has in balancing the budget while convincing your colleagues of the sacrifices our men and women make. But I also emphasize our need for your continued support for improved housing opportunities, education, child care, medical, MWR, and pay compensation. These quality of life concerns are imperative if our personnel are to keep pace with the civilian economy and remain proud, dedicated, professional members of our Navy. Thank you.

BIOGRAPHICAL SKETCH

Duane R. Bushey was born on May 3, 1944 in Lebanon, New Hampshire. Following graduation from Wicomico Senior High School in Salisbury, Maryland, he enlisted in the Navy in June 1962.

Master Chief Bushey received recruit training at the Naval Training Center in Great Lakes, Illinois and completed Aviation Electrician "A" school in Jacksonville, Florida. He first saw duty at the Naval Air Test Facility at the Naval Air Station in Patuxent River, Maryland, followed by further technical training in an advanced electronics "B" school. He then served on board the aircraft carrier USS Kearsarge (CVS-33), with two follow-on tours as a flight instructor for fleet replacement navigators with Heavy Attack Squadron One Twenty-Three (VAH-123) at the Naval Air Station, Whidbey Island, Washington and Tactical Electronic Warfare Squadron One Thirty (VAQ-130) at the Naval Air Station in Alameda, California, where he served as Celestial and Radar Navigation Instructor.

Master Chief Bushey then served as the Assistant Aircrew Division Officer for the Aircraft Ferry Squadron Thirty One (VRF-31) in Norfolk, Virginia. While serving with VRF-31, he qualified as an overwater navigator in several aircraft, as flight engineer for P-3 Orion aircraft and bombardier/navigator for A-6 Intruder aircraft.

Master Chief Bushey was selected to attend the U.S. Army Sergeants Major Academy in Fort Bliss, Texas in January 1980 and while there received the General Ralph E. Hanes Jr. Award for outstanding research. Following graduation in July 1980 he returned to VRF-31 as Command Master Chief. He then served as Command Master Chief for Commander Tactical Support Wing One in Norfolk, Virginia followed by a tour in 1985 as Command Master Chief in Theodore Roosevelt (CVN-71). On September 9, 1988 Master Chief Bushey became the seventh Master Chief Petty Officer of the Navy.

Master Chief Bushey is entitled to wear a Meritorious Service Medal (two awards), Navy Commendation Medal (two awards), Navy Achievement Medal, Good Conduct Medal (six awards), Meritorious Unit Commendation and Battle "E" (two awards). He is designated an Enlisted Air Warfare Specialist and has accumulated more than 6,000 flying hours and made more than 400 carrier landings.

Master Chief Bushey has received special recognition as Commander in Chief, U.S. Pacific Fleet Sailor of the Year for 1972 and Tidewater Virginia's Military Citizen of the Year for 1982. The Bushey family was selected as Tidewater Military Family of the Year for 1988.

Master Chief Bushey is married to the former Susan Walker Frause of Salisbury, Maryland. They have a daughter Terry and two sons, Duane Jr. and Joseph.

STATEMENT OF CMSAF JAMES C. BINNICKER, CHIEF MASTER SERGEANT OF THE AIR FORCE

Senator INOUE. Now the Chief Master Sergeant of the Air Force, James C. Binnicker.

Chief BINNICKER. Thank you, Mr. Chairman and thank you for the opportunity to appear before this committee.

The average airman in our Air Force today is a 27-year-old E-5 maintenance troop. He has 7 years in the Air Force, 2 years of college, and he is married with two children.

His No. 1 concern is his jet—his airplane—but he sees the world like this: his promotion opportunities are down. VHA rates are down. If he lives in Alaska he is losing money.

ENLISTED BENEFITS

He lives in military family housing that is 25 to 30 years old, too small, hard to get. Medical care for dependents is no longer a sure thing and now someone is suggesting a user fee for all the wrong reasons. MWR prices are going up. Pay raises of 3 to 4 percent are common and his retirement is being threatened.

Now, I can explain each of these items individually and he will understand that. But when he looks at the total list, it is like a dark cloud on the horizon. Yes, recruiting is good. It is the highest

quality ever. Overall retention is good, but with job opportunities on the outside improving every day, who knows? Our maintenance troop may be put in a position of having to make a tough decision.

We cannot compete with the outside, dollar for dollar. Where we can make a difference is, we give them a meaningful career, one that allows them to grow; give them a good standard of living; give them an environment of trust and security; let them feel they can provide for their families wherever we send them.

THE AIR FORCE CARES

One of the reasons I believe we have been so successful in retaining quality folks is that they see we care. We really care. We give them levels of responsibility that challenges every bit of mental fiber they possess. They feel important. They feel like they are part of the team, that they contribute to the mission.

In return, they want security. They accept and understand the military life: the long hours, the overseas assignments, remote duty separated from families and not being home when newborns arrive, frequent TDY away from families. They know they are not going to get rich. They just want the security of knowing the Government they serve will take care of them.

Recently I visited McLellan Air Force Base in Sacramento, CA. I went through the technical operations division and was briefed by a young senior airman, an E-4 named Mike Acker, working in a very high tech environment on a very highly classified job.

After the briefing, I was amazed at the level of responsibility we have given this young E-4. He is single. He lives in the barracks and could leave on his discharge and quadruple his salary and I asked him why he stays. He said he likes the challenge and he likes the responsibility we give him.

I asked him, "What would it take, Mike, to keep you in the Air Force?" He seemed to be relatively happy with his plight in life and he said, "Well, one thing that really rubs me the wrong way is I have to share a room in the barracks. I have a roommate. My room is 180 square feet." One hundred eighty square feet for this highly sophisticated, high tech young man.

Mr. Chairman, members of this committee, we have the best Air Force ever. We can ill afford to allow the attitude of the late 1970's to creep back after 10 years of hard work rebuilding experience levels, rebuilding trust and confidence. That attitude being, I like the military, I just cannot afford to stay in.

I stand ready to answer your questions.

Senator INOUE. Thank you very much.

[The statement follows:]

STATEMENT OF CMSAF JAMES C. BINNICKER, CHIEF MASTER SERGEANT OF THE AIR FORCE

Mr. Chairman and Members of the Committee, I appreciate the opportunity to appear before you today to discuss the most pressing issues facing the enlisted members of the Air Force. Let me start by thanking you for your past support for people programs. They have allowed us to build the best Air Force in the history of this country, and, to my mind, the world.

The enlisted men and women of the Air Force are top quality and they are ready to do their job of defending this nation. They are committed to readiness and training and their enthusiasm is boundless. As I travel, they continually impress me

with their dedication, patriotism, loyalty, and desire to do the absolute best they can.

The Air Force is committed to maintaining this level of quality. We strive to recruit the best, and then we train them to be prepared. However, to retain them we must have a compensation and benefits package which recognizes their mission. It must not only compensate them equitably and fairly, but must also provide for their families and their future.

Our members are well aware of the problems this country faces because of the deficit and they have accepted the budget cuts over the past several years as necessary. However, as a result of conversations with the troops over the past three months, I believe we may have turned down the same road we did over a decade ago. The tones and questions are beginning to sound the same as those I heard in 1977 and 1978.

In 1979, a combination of economic factors, successive military pay caps, and expanded private sector job opportunities drove many of our most talented and experienced noncommissioned officers out of the service. Similar conditions are appearing today. Despite good overall retention, shortages do exist, particularly in our high-tech and sortie-generating skills. Members with these skills are being offered lucrative opportunities with commercial companies. We must remember that low retention results in lower experience and increased training and replacement costs. Therefore, we must emphasize retention as we evaluate priorities within the budget.

What is it that our people want? They want a standard of living that is commensurate with the mission they perform and equal to the nation they defend. They want a predictable, dependable, and equitable compensation and benefits package.

The major issues plaguing the enlisted force today are: Pay and allowances; housing; medical care; permanent change of station costs; retirement; and family matters.

PAY AND ALLOWANCES

Why is a military pay raise needed? Our members know their pay has not kept pace with either their civilian counterparts' or inflation. The comparability gap stands at 10.1%, and pay lags inflation by 1.2%. These numbers are bad enough; however, they point to a larger problem—the unpredictability of the current pay raise mechanism. Our members deserve and want a system upon which they can depend for fair and competitive raises and which will, at a minimum, preserve their standard of living.

A recent survey revealed that retention impacts may soon be felt because of the lag in pay. Over 60% of members surveyed believed higher-paying jobs are readily available in the private sector. With a 1988 unemployment rate of 5.5%, they may be right. Also, over 70% believed private sector pay and benefits are generally better than military compensation.

The stage is being set for our members to leave the military as their predecessors did in the late 1970s. Loss of purchasing power erodes our people's standard of living; lack of pay comparability with the private sector tells them they can make more money in the civilian economy; and low unemployment makes jobs readily available. The enlisted force knows these facts and they know history. They ask why they should stay and accept compensation policies that cap their pay and erode their standard of living—signals that their service is not valued.

Accordingly, the 3.6% pay raise contained in the President's Budget is a bedrock necessity. Anything less will further erode not only our members' purchasing power and their standard of living, but it would send a signal that until we again lose vast amounts of experience, fair and competitive raises will not occur.

HOUSING

The issues of adequate on base housing, and affordable housing for members residing on the economy, is becoming more critical to the troops everyday. Any measurement of a person's living standard must include their housing. Our members living on-base deserve family housing that is comparable in amenities and size with the civilian world. Many of the current housing units are 30 to 35 years old and are too small, have too few bathrooms, and lack adequate kitchens (including a dishwasher) and family room. When on-base quarters are not available, our people need a housing allowance system which compensates them at a suitable level for the area to which we order them for duty.

The No. 1 issue for our airmen in the barracks is privacy. They want to be able to sleep undisturbed and know their belongings are secure. They do not want to share

bathrooms. When we cannot provide quarters for these members, we must ensure they receive allowances sufficient to rent affordable and adequate accommodations.

The solution to these issues lies in a variety of fixes. We must have a military construction budget which allows us to update military family housing. This must also include new and innovative financing methods. We should embark on a game plan to provide private rooms and baths to our members in the barracks. Finally, we need allowance systems which permit all members to obtain adequate housing for themselves and their dependents, regardless of the location to which we assign them. The Overseas Housing Allowance system is serving its purpose. Within the United States however, we need an uncapped Variable Housing Allowance (VHA) system.

I realize the VHA is an allowance; however, it directly impacts our members' housing decisions. VHA is designed to recognize that the military orders members to move between areas with very different housing costs. It was designed to ensure that members can afford adequate housing regardless of where we assign them in the continental United States. However, since first authorized in 1980, this allowance has been totally restructured, and rates have either been frozen or limited by unrealistic expenditure ceilings. Basically, it has not been allowed to function as intended. In addition, Alaska and Hawaii (treated as overseas locations for almost all other purposes) have been added to the program, and an "Offset" has been required from members who find housing for less than their allowances.

Based on these factors, our members no longer believe the VHA system is working. I can explain the ideal, but not the reality. On 1 Jan 89, 68% of Air Force VHA recipients had their rates reduced. Fortunately, with the increase in basic allowance for quarters, two out of three members received an overall increase in housing allowances. Still, almost 3% of our members took a net pay loss after the VHA adjustments. Without any hesitation, I can say that one-third of our members did not have their rent reduced on 1 Jan.

We need your support to allow the program to operate as intended when it was restructured in 1985. The basic allowance for quarters should cover 65% of the national median housing costs by grade and dependency status. The member should be expected to pay 15% of the national median and VHA should then pay the member for the difference between local median housing costs and 80% of national median. That is the ideal. The reality is that today the average member is paying 21.5% of housing costs from basic pay. For our enlisted troops, this is a significant added financial burden to place on a compensation package already feeling the eroding effects of inflation.

The solution is two-fold. The first is your support of the 3.6% variable housing allowance (VHA) inflation increase in the President's Budget. Secondly, we urge you to refrain from imposing any expenditure ceilings on VHA in the Appropriations Act.

MEDICAL CARE

For many years, our military members claimed that we said we would take care of their medical needs, plus the medical care of their dependents. Now, we are accused of reversing this decision when we ask them to check the fineprint—care for your dependents and for you following retirement is on a space available basis. In today's medical environment, facilities for dependents and retirees are strained to the breaking point. We require them to use the increasing high-cost CHAMPUS alternative or wait for extremely long periods at military treatment facilities. Our members believe they have been lied to, even though care for nonactive duty dependents has always been provided on a space-available basis.

I know many programs are under consideration to provide adequate medical care to our members and their dependents. However, the Force wants an answer. They want to be assured that their dependents will have medical care available regardless of where the member is stationed, and they want to know what will be available for them and their dependents upon retirement. They want and deserve a firm commitment.

Regarding the proposed 2-year test of a medical user or co-payment fee, I find it difficult to logically explain it to the Air Force enlisted member. They view it as another slap in the face. The idea of a test only adds to their apprehension about the reliability of medical care for them and their dependents. They ask whether or not they should consider medical benefits in their career decisions.

On a positive note, the Dependent Dental Plan implemented in August, 1987, has been well received by our members and their families. This plan provides the basic

dental needs for dependents of active duty members. We thank the Congress for this benefit and your support.

To improve the medical care provided our members and their families, the Air Force solicits your assistance in funding all initiatives to improve medical care. After studying all the options, we will determine the best alternatives, and then we will ask you to guarantee our members the future of their medical benefits. They deserve this guarantee.

PERMANENT CHANGE OF STATION (PCS) COSTS

On 1 July, we will implement new household goods weight allowances for the majority of our members. Congress' approval of this initiative last fall is viewed by our members as a major improvement in PCS allowances and is greatly appreciated by the military member. However, our members will still incur significant out-of-pocket costs incident to a government-directed PCS move. Surveys of Air Force members continue to show that for every \$3 the member spends on a PCS move, the Government reimburses only \$1—real time negative compensation. OSD is now looking more closely into this issue with an extensive survey of members in all Services making a PCS move. Results are anticipated by the end of the year.

In 1986, the Armed Services Committees increased the dislocation allowance (DLA) payable for PCS from one month's basic allowance for quarters (BAQ) to two months' BAQ. The DLA is designed to reimburse the member for miscellaneous expenses incurred incident to establishing/disestablishing a home. While two months' BAQ is authorized, the annual Appropriations Acts have limited payment to one month's BAQ.

RETIREMENT

Commitment is the key when we discuss retirement. Air Force enlisted members do not believe they have a retirement system upon which they can depend. Over the past ten years, the retirement system has been repeatedly modified; always downward. The troops want a system upon which they can plan their futures. They need to be able to tell their families that following twenty or more years of service, they will have a retirement check that will maintain its full value each year. They want to know that their standard of living will not decrease each year following retirement and that in return for their commitment to defend this country, the country will honor them with a dependable retirement system. Is this too much to ask?

In the past, the retirement system has been a major drawing factor for members to make the military a career; we are now hearing discussions that the uncertainty of the system is a demotivator. We solicit your support to honor past commitments and to guarantee a permanent retirement system for all military members.

FAMILY MATTERS

Air Force leadership recognizes that families have the major voice in career decisions. Therefore, they have a direct impact on readiness. With two-thirds of our members having family responsibilities, we know that the well-being of the family affects the morale and productivity of the military member. In today's environment, it is essential that we consider the family in our decisions. This only supports the need for adequate pay, housing, medical care, PCS reimbursements, and a stable retirement system.

In recognition of the impact of the family, the Air Force is establishing Family Support Centers at 123 major installations. These centers identify, develop, and coordinate programs that improve the well-being of the family. They assist in spousal employment; financial counseling, relocation assistance, and other areas that play a part in the attitude and well-being of the family.

Feedback from the Senior Enlisted Advisors of the Major Commands shows that the Family Support Centers are having a positive impact on our members and their families. The Advisors and their bosses, the Commanders, are anxious to have centers open on all their bases. Accordingly, we hope you will assist by ensuring requested funding for Family Support Centers is approved.

CONCLUSION

Naturally, there are other issues being discussed by Air Force enlisted members; however, I have covered the major ones. They all appear to revolve around the issue of commitment.

Air Force enlisted men and women are committed to defending this country, to include giving their lives if necessary. They are top quality and they are trained to do their job. They want to serve their country and they will.

Still, they have started to believe that the people who control their lives do not feel committed to maintaining a decent living standard for military members and their families. They justify their position by citing pay caps, inadequate housing and housing allowances, undependable medical care, inadequate reimbursements for permanent change of station, and talk of more changes to the retirement system.

While you make the hard decisions you must to resolve the deficit problem, I hope you remember the dedicated members standing guard to protect this country. In your decisions, please consider the mistakes made in the late 1970s, and the tremendous costs associated with recruiting and training the new members on board today. Give them a predictable, dependable, and equitable compensation and benefits system and they will stay as your guardians.

It will be a pleasure to answer any questions you might have.

BIOGRAPHICAL SKETCH

Chief Master Sergeant of the Air Force James C. Binnicker is adviser to the secretary and the chief of staff of the U.S. Air Force on matters concerning welfare, effective utilization and progress of the enlisted members of the Air Force. He is the ninth chief master sergeant appointed to this ultimate noncommissioned officer position.

Chief Binnicker was born July 23, 1938, in Orangeburg, S.C., where he graduated from Aiken High School in 1956. He graduated from the U.S. Air Force Senior Noncommissioned Officer Academy in 1973 and the First Sergeant Academy in 1974.

He entered the Air Force in August 1957 and received basic training at Lackland Air Force Base, Texas. He was then assigned to the 96th Air Refueling Squadron, Altus Air Force Base, Okla., as a life support specialist until 1963. He then cross-trained to the air operations career field and transferred to the 816th Strategic Aerospace Division, also at Altus, as an air operations specialist. In July 1964 he was assigned to the 1502nd Air Transport Wing (later became 61st Military Airlift Wing) as noncommissioned officer in charge, wing operations, Hickam Air Force Base, Hawaii.

From August 1967 to August 1968 Chief Binnicker served with the 4th Strategic Aerospace Division, Grand Forks Air Force Base, N.D., as NCOIC of base operations. He then transferred to Binh Thuy Air Base, Republic of Vietnam, where he served as NCOIC of base operations with the 22nd Tactical Air Support Squadron. While in Vietnam he was assigned to the Republic of Vietnam Armed Forces Language School, Saigon, as a language instructor. Leaving Vietnam in September 1969, Chief Binnicker moved to Robins Air Force Base, Ga., as an air operations superintendent in the 58th Military Airlift Squadron.

He became the NCOIC of wing operations, 374th Tactical Airlift Wing, Ching Chuan Kang Air Base, Taiwan, in May 1971. Upon returning to the United States in August 1972, the chief served as operations superintendent, base sergeant major and wing senior enlisted adviser with the 4th Tactical Fighter Wing, Seymour Johnson Air Force Base, N.C. In September 1975 he was assigned to 12th Air Force, Bergstrom Air Force Base, Texas, as the senior enlisted adviser.

Chief Binnicker served as the Air Force enlisted representative and senior enlisted adviser on the President's Commission on Military Compensation from October 1977 to April 1978. He returned to 12th Air Force as senior enlisted adviser and in June 1978 he was appointed senior enlisted adviser to the commander in chief, Pacific Air Forces, Hickam Air Force Base. In June 1981 the chief was assigned to Randolph Air Force Base, Texas, first as chief of the Enlisted Retention Division, Manpower and Personnel Center, and in May 1982 he was appointed assistant for chief master sergeant matters. In February 1985 Chief Binnicker was selected for the 33 Year Extended Tenure Program. He became senior enlisted adviser to the commander, Tactical Air Command, Langley Air Force Base, Va., in May 1985. He assumed his present duties in July 1986.

His military decorations and awards include the Legion of Merit, Bronze Star Medal, Meritorious Service Medal with three oak leaf clusters, Joint Service Commendation Medal, Air Force Commendation Medal with one oak leaf cluster, Vietnam Service Medal with three service stars, Republic of Vietnam Gallantry Cross with Palm and Republic of Vietnam Campaign Medal.

He is married to the former Jan Chambers of Kenansville, N.C. They have two sons, Carmen and Michael.

STATEMENT OF SERGEANT MAJOR DAVID W. SOMMERS, U.S. MARINE CORPS

Senator INOUE. Our final witness is the Sergeant Major of the Marine Corps, David Sommers.

Sergeant SOMMERS. Good morning, Mr. Chairman. As we move forward toward the next century we are continually faced with a new and bigger challenge. Being prepared continues to become more and more complex, more technical and more demanding with longer deployments and more family separations.

Doing more with fewer Marines, less money, and doing it better than our adversaries has become the name of the game. We have the weapons and equipment we need. We know how to use them, and we have the will and the spirit to win. Now, at this very moment, we are ready to do whatever needs to be done in the defense of this great Nation.

We have taken what you have given us and we have used it wisely, as you would expect us to, but now we need your assistance and support in other areas—specifically quality of life issues.

Today, as we talk about such areas as pay, housing, medical care, and other quality of life issues, be ever mindful that we bring you the concerns of our men and women around the world. We have not come here with surveys, percentages or studies, nor have we come here asking for a handout. We have come here seeking your needed support with our observations from the field and the concerns of those men and women that serve around the world.

Yours is truly a difficult task: where to use our Nation's money where it will do the most good for our Nation. We understand the limited resources you are working with and we know that you will make every effort to do the very best possible job with your assets.

Thank you, and I stand prepared to answer any questions.
[The statement follows:]

STATEMENT OF SGT. MAJ. DAVID W. SOMMERS, SERGEANT MAJOR OF THE MARINE CORPS

Mr. Chairman and members of the committee:

I am Sergeant Major David Sommers, Sergeant Major of the Marine Corps. I appreciate the opportunity to speak to you this morning on my views about the quality of life of our marines. I do not want to belabor the obvious, so I won't take up your time in going over the difference in the quality of today's marine from the past. The difference is both well-known and well-evident. Militarily, the difference is essential. The very nature of the next conflict will likely require the courage of past wars but many times more spontaneous judgement and initiative. The information revolution has impacted military life directly and has translated into greater requirements for intelligence, initiative, and tactical creativity at much lower levels on the battlefield. As a result, we recruit for intelligence and reliability, and we have done so successfully.

In addition to improved quality, we train our marines better today, so we get more marine for the money. Our training is more realistic, and our overall readiness is higher than at any other time in my career. Pound for pound, dollar for dollar, we have more combat-ready firepower than ever before. Real skills for real situations are being practiced and performed. As a case in point, the first contingency marine air-ground task force to deploy to the Persian Gulf sailed with less than two days preparation. Yet, it was manned wholly with marines who had been conducting nothing more than routine training. Once there, they reacted to an array of threats and missions under chaotic, uncertain circumstances, with professionalism and discipline.

Today's Marine Corps is the only force this country has that can achieve all its assigned global war fighting requirements short of general war without mobilizing a man. Even if we were to mobilize, our reserve forces are combat ready. During our

most recent exercises in Norway, reserve units excelled in deployment preparation as well as actual training.

None of this is intended to disparage our former marines; marines have always risen to the task at hand. While no one could have known on the beaches of Tarawa or Iwo Jima, at Inchon or even in the jungles of Vietnam, what we would be facing today, we made an unconditional social obligation to them for their sacrifice.

I believe that cuts to our retirees' benefits have been mentioned all too frequently as cost-saving measures. I believe in the strongest terms that our commitment to them is inviolable and that any compromise is unconscionable. There is no doubt that our treatment of retirees has an impact on young men and women entering the service today. In contrast to the past, today's marines have much different expectations of the service. Just as the information revolution has touched the armed services directly in changes to our means of war, it has impacted indirectly as well in the increased sophistication of our youth prior to entering the service. With greater education and intelligence comes greater awareness of the world. Career decisions are made much earlier—in many cases, the decision to join the service itself is a career decision. A good job and a family, which used to be long-term goals, are important to many high school graduates during their first enlistment.

In the last three years, for the first time, we have had more dependents than marines. Today, over 42% of our marines are married. Two out of three families have children under the age of eleven and over half of the spouses work outside the home. One out of three spouses is under the age of twenty-four. Family support cannot be overlooked, if only for the sake of combat-readiness.

Quality of life issues directly impact on our war-fighting capability. We have recruited good people, we have prepared them for combat, and now, to keep them effective and in uniform, we have to help them take care of their families. Despite the welcome pay increases under President Reagan, last year, almost \$400,000 was received in food stamps at Marine Corps commissaries. We can only speculate on how much marines spent off-base in food stamps or even more importantly, how many were eligible for the assistance but too proud to ask. Only when our pay approaches, and stays in line with the civilian community, will we be able to assure our marines that their reward for service will not be poverty.

With the bachelor and married housing projects initiated in the past few years and the planned construction for this year, we have made significant inroads into eliminating our housing deficit. Family housing remains a severe problem, especially in our west coast commands. In southern California and Hawaii, we still can't house them all on base. We urge you to support our family housing and single housing initiatives.

While we have reduced the number of unaccompanied tours overseas, we have increased the amount of training, causing young marines to face more numerous short-term deployments to Okinawa, shipboard deployments, and deployments for training away from their home base. For these marines, life in the field and on foreign shores is inevitably more stressful. The cost of maintaining two households, the separation of the family, the burden of child care are all detractors from readiness.

As you know, we are requesting two more child development centers in fiscal year 1990. This year we also expect to double the family day care program. Our family service centers, in conjunction with the larger efforts of the Department of Defense and Navy, provide employment resource centers, and other essential services for our Marine Corps families.

The last area of some concern to me is medical care. Across the country, the availability and cost of health care is a concern to many. The Department of Defense and the Department of the Navy have started a number of innovative programs such as the Navcare Centers and the CHAMPUS innovations in California and Hawaii. Quality health care cannot be solved by any one service or even the whole Department of Defense. Competition for manpower and rising health care costs make the subject of the greatest concern not only for our dependents and retirees, but for our active duty combat readiness as well. I have seen the impact of these programs among our forces. We support increases in these programs. We cannot rest until our obligations are met for all our people.

Sir, this concludes my remarks. I appreciate the opportunity to address you this morning. I look forward to answering any questions you might have.

PROBLEM OF RELATIONSHIP

Senator INOUE. Before proceeding with my questions, I would like to thank all of you for being with the committee this morning,

but also to suggest to you that there is an underlying problem in our relationship here.

Most Members of Congress are a half a generation behind what is happening today. We often times remind ourselves of our experiences and relate to our backgrounds in dealing with today's problems.

I served in the military when the pay was \$21 and less than 5 percent of the men had wives and children and they were either volunteers or they were drafted, and it was wartime. When I left the service as a captain I believe my pay was then \$200. That's my background, and if I do not watch myself I would compare that with this moment. So I am constantly watching myself as part of the exercise.

The senior members of this subcommittee will be spending 2 weeks primarily with the enlisted personnel in the Middle East and in NATO. We will be spending time, and a lot of time in Germany with the Army and the Air Force. We will be spending at least a day in the Persian Gulf with your fellows, having meals and chatting with them. We will be spending time with families to find out for ourselves.

ALL-VOLUNTEER SERVICE

I would like to ask, first, a broad question to all of you. Although we are now an all-volunteer group, there are many who are still suggesting that we should go back to the Selective Service System to make certain that since this endeavor of defending the country is so important that all men and all women should have an equal risk in serving, if there is such a thing as a risk in serving. What are your thoughts on the draft, Sergeant Major?

Sergeant Major GATES Sir, while a national service program certainly sounds like the right thing to do, and I am probably out of order by saying that in my opinion every male and female should serve their country at a certain age level.

Having said that, it certainly would take somebody with more ability than I have to make a good and complete analysis of the cost and see if we would save funds in the long run.

I believe that a national service program would have an effect on our ability to recruit quality soldiers into our Army. I go back a short distance in history and refer to the Army of the 1970's, where we had very high indiscipline rates and we had many soldiers entering the Army who did not complete their enlistments. We have overcome that.

Today, sir, we have a quality Army and our Army can be deployed at very short notice to any part of the world. The morale and esprit of our Army today is as good as I have seen it during my three decades of service in the Army and to this country, so I would caution our national leadership of taking actions that would change the quality of our Army.

Chief BUSHEY. I believe that the all-volunteer force has brought us the quality we have today. As you are well aware, the Navy never did really get involved very deeply into the draft situation. We are very technical today. The Army is much more technical; the Navy is much more technical. All of our services are.

I am not sure if we went to a draft if we would get the quality that we need. And if we could sell a 4-year program with a draft, I believe the draft has always been pretty much a 2-year program, that cost of additional training may not be worthwhile. I think we really need to build a quality of life issue where we can attract the quality we need and keep.

I think our retention needs to be much, much higher. We need to keep more of the people that we bring in. And that would help reduce the recruiting effort we have. So I would rather see us put our attention on that. As far as the national services, if you want to tie that in with the draft, me personally looking at it, and not as the position of Master Chief of the Navy, with me personally, I do not see where it will work.

And I ask people as I travel, if you had the choice of working in a park system and getting a \$10,000 scholarship or coming in the military for 4 years and getting a \$20,000 scholarship, what would your choice be? Most of them pick the \$10,000 and get on with my life rather than serving the military.

So I think it would hurt our recruiting effort, the national services.

Senator INOUE. Thank you.

Sergeant Major Sommers.

Sergeant SOMMERS. Sir, I am not a big fan of the draft at all. I was a drill instructor at the time of the draft and I know the type of individuals that we had to deal with—never knowing whether the FBI was going to show up and haul them off before you finished the training day or not.

So I am not a fan of the draft. We have a quality force and a draft may cause us to have to lower our standards. With the sophistication of equipment that we have today, we cannot afford to lower our standards.

I am very comfortable with the quality of Marine that we have today. Our retention is good. Our recruiting is good. I am not saying that we won't falter some as we get into the next couple of years where the market of those that are eligible to join the military is dwindling. But I am very comfortable with the volunteer force that we have.

As far as working for scholarships and for housing loans and that sort of thing with the national service, that may be an acceptable alternative by giving those that do not have the opportunity or do not qualify to serve in the military, the opportunity to serve their country in other areas. I am sure that the committees that have cognizance over the National Service Program, should that materialize, will take these kinds of things into consideration. But as far as the military goes, I am very comfortable with the all-volunteer force, sir.

Senator INOUE. Thank you.

Chief Master Sergeant Binnicker.

Chief BINNICKER. Sir, I am opposed to the draft. The Air Force has never had a draft, never saw the need for one. I think that the draft, if we put it into effect today, would cost us more money in terms of recruiting and training costs, primarily the training costs. The morale would not be as high as it is today, the dedication, the esprit de corps that takes us through the tough times.

So I would be opposed to a draft. As far as the national service question, I would endorse that, but I would not endorse it for the military as being part of that. There are many programs in our country that need the youth of America to get involved. But the military being a military organization, I think we would very quickly turn into a babysitting organization.

UNACCOMPANIED TOURS

Senator INOUE. Thank you very much.

I believe at the present time, most of the Marines, the artillery, infantry, and such, go on a 6-month tour of duty overseas. On that tour, dependents do not accompany the Marines.

On the other hand, we have members of the Army, Air Force, and Navy who have overseas assignments, such as in NATO, and their families accompany them. There is some discussion, I have been told, in the higher echelons. They are looking into the possibility of changing the rotation system, for example, in the Army and the Air Force, to follow the Marine example of 6 months without dependents.

What are your thoughts, Sergeant Major Gates?

Sergeant Major GATES. Sir, since the majority of our Army is married, about 56 percent fall into that category, it is imperative that we do what we can to maintain the family integrity.

One of the reasons that soldiers remain in our Army is because they do have the ability to live and perform duty near their families. I strongly believe that any additional family separations—that is, in addition to what we already require of our soldiers—would have a detrimental effect on our families. And certainly, it would have a detrimental effect on our abilities to retain soldiers in our Army.

We do have soldiers who serve on unaccompanied tours in many parts of the world. Korea is a good example. We have thousands of soldiers that do serve a 1-year unaccompanied tour. And some parts of Europe fall into that category.

I believe if we change the system that we would see a drastic change in the family divorce rate and a change in the family support system used.

In addition, we certainly would have to build or construct additional family support activities at our bases within CONUS to implement this program.

Sir, I believe if we adopted a program of a 6-month rotation for our thousands of soldiers who are stationed overseas and increased separation from their families, it would have a detrimental effect on our Army. And we would have a tough time meeting our recruiting and retaining goal.

Senator INOUE. Master Chief Petty Office Bushey, any comments?

Chief BUSHEY. Well, I think mainly what we would be talking about is the forward deployed. Most of our deployments are 6-month deployments, but we do have a group of ships that are stationed in Japan. And I think that has been very cost-effective for us in that it takes so much time to get from the west coast over into that area.

And the Japanese Government has done so much in improving the quality of life for our families and our sailors there. Just recently, I made a trip there. And that has improved tremendously. And so I think for that area, I really support our families going along with our sailors.

It is still not an easy task at all. It is very, very difficult. But if we went with a 6-month rotation, we could not operate our ships that way. So then you have the question of bringing the ships back and would that be cost effective also. I do not believe so.

In Italy, we have got a lot of work to do there. I think you are going to be shocked when you visit there and see some of the conditions that our people are living in there. And we know we have to do a lot of work in that area.

But bringing our ships out of there, I do not think would be the right answer either. There is very little opportunity left for a sailor to spend time with their family. We have seen the shore duty billets dwindle. In order to man our ships, we have had to take from our shore stations, which is, some of them are 70- and 75-percent manned as I go around, which has really increased the workload when you go to shore duty, too. And so it is an unpopular thing.

But I always like to tell it like it is. To me, there really isn't any shore duty left for a sailor today. When you do go to shore duty and you go to a training command or you go to a readiness air group, you are still putting in 12-, 14-hour days, sometimes you are working 14, 15 days without a day off.

And so some of them look forward to these overseas where they can bring their family. The workload is still heavy, but at least you get to tie up next to your family at night. And that is worth a lot.

Senator INOUE. Sergeant Major Sommers?

Sergeant SOMMERS. Sir, we also have Marines stationed in places like Okinawa that have 1 year unaccompanied tours. I believe that much of the success for our 6-month deployments has to do with what I like to refer to as the family support system. Our dependents and our families have become as much a part of a deployment as the deploying unit. We go into an awful lot of work preparing the families to remain home. The wives of the staff noncommissioned officers and the officers take charge of that whole homefront scene while that battalion is deployed. They are the unsung heroes of our 6-month deployments. You do not hear a lot about them. They are left back with the task of holding the families together in the interim.

We are comfortable with our 6-month deployments. Obviously, different services have different missions. Navy and Marine Corps 6-month deployments are very, very necessary. We could never do it by taking our dependents for a year at a time.

Senator INOUE. Chief Binnicker.

Chief BINNICKER. I think with the number of people we require to be overseas in the Air Force, to change the rotation schedule would be detrimental to the good of our business and training costs would go up, readiness would go down. The continuity would be lost. Morale would certainly be impacted in a negative way. And I think that it would be not an attractive service to join as it is today.

SPOUSAL AND CHILD ABUSE

Senator INOUE. I hope you will not assume that since I am asking the questions, I am in favor of the proposition.

About 12 years ago, I was able to convince CINCPAC that he should look into the matter of spousal and child abuse. Up until then, none of the senior officers would even consider this. It was unheard of to have spousal and child abuse in our services. I said, you better look at the police record and you will see that the rate of incidents are much higher than in the civilian sector.

I am happy to say that we started with Hawaii and then spread throughout the services. We now have family services and child welfare type arrangements.

Is it working?

Chief BINNICKER. I think it is working very well. And I applaud your efforts to cause that to happen. Because it was long overdue. And I think our family advocacy and family support center programs are focusing on that. And it is working very well in the Air Force.

Senator INOUE. Sergeant Major Sommers.

Sergeant SOMMERS. Sir, the family service centers are certainly doing what we wanted them to do. But I believe there is an area that we still have an awful lot of work to do. It is not a subject that most of us like to talk about, but it is a subject that we have enough of in the military, as in society, that needs to be looked at very closely. That is in child abuse; more specifically child sexual abuse.

This is a subject that is very difficult to speak to when you are talking to a large body, because the mindset of the American public is immediately to do something about the perpetrator of the crime. When we do this, we destroy the family in the interim. We remove that member by throwing them out of the military; whatever the case might be and we punish them under the UCMJ. The family then becomes the victim. Again this is an area that needs to be looked at, and looked at very closely.

General Gray came on line with a letter to the commanders dealing with this. It is a very unpopular subject, but it is something that is in the military, as in society, and we are still learning how to deal with it. And I think if there is an area where we need more guidance, more assistance in the family services, this would be it.

Thank you, sir.

Senator INOUE. Master Chief Petty Officer Bushey.

Chief BUSHEY. I would like to say, my fellow sea service put it exactly the way it had to be said. I feel the same way. Our family services have really helped our families a lot. A tremendous program and we need to put more money into that area. And maybe even fence it where the local commanders cannot take away from those programs.

Family advocacy, child abuse is an area we need to learn a lot on. And we still have an awful long way to go. I think in the Navy we have a good program, as far as it being written on paper and instruction. But that was one of my personal goals coming in as Master Chief of the Navy, to try to make the family advocacy program work like it is supposed to work.

I do not think we are any worse off than society, but I believe we should lead society, and we have got to tackle that issue. And I do not think we are doing as good as we could. We have some good people working in the program, we just need to get it all together; put the proper money into it so we can get the proper counselors, so that we can hire counselors so that they know they have a job for at least 3 to 5 years, not a contract that is going to last 6 months or a year.

And we are paying them salaries like \$15,000 and they can get out of the Navy Family Advocacy Program tomorrow and go out and set up their own counseling services, where they are getting \$60 to \$100 an hour. We just cannot keep good counselors in the program unless we fix that. We have got to—not throw money at it—but we have got to support it with the proper amount of money.

Senator INOUE. Thank you.

Chief Sergeant Major.

Sergeant Major GATES Sir, I, too, would like to applaud your efforts in this endeavor. One of the bright parts of the program is, now, we are seeing our abused spouses come forward and indicating to the chain of command that they are in fact being abused. And the same thing applies to child abuse. So that is a plus. And it is something that has been long overdue.

And it is working. Again, I would like to echo my fellow noncommissioned officers. We certainly need to continue to work the programs in our community services to bring them on line with the other quality of life programs that we have.

But, overall, it is working. And those who do abuse their wives or spouses or children, we are seeing action being taken in the right direction.

Thank you, sir.

Senator INOUE. Thank you.

Before I proceed with other questions, I am pleased to call upon the senior member of the committee, who was chairman not too long ago. And his record in support of enlisted personnel, I am certain you are all aware.

Senator STEVENS.

Senator STEVENS. Thank you very much, Mr. Chairman. I am sorry I was late. I had a group of Alaskans in town. And as you know, when people come to see us, the chairman and I, they come from such a long distance that they deserve an audience. And so we appreciate the fact that you went ahead with the hearing.

DEFENSE EXPENDITURES

I would follow up, first, what I understood the chairman's question to be as I came in, just with a comment. If the trend line is going to be really down in defense expenditures, and that appears to be the case, we are going to have to make a major decision concerning the future of the modernization program.

So I feel constrained to ask you the same question I did the senior officers that appeared before us at our last hearing. And that is, if we have to make a decision concerning the costs of deployment overseas, do you believe that accompanied tours are so

important that we should reduce personnel numbers overseas rather than reduce the number of accompanied tours overseas?

Chief BINNICKER. I would vote for reducing total numbers overseas as opposed to restricting the accompanied tours.

Senator STEVENS. Sergeant Major Sommers, what would you feel?

Sergeant SOMMERS. Sir, I do not really believe I understood exactly what you were saying, sir.

Senator STEVENS. What if we get to the point where we decide we only have so much money for deployment forces overseas and we have to make a decision as to whether to have fewer troops overseas or more unaccompanied tours. Accompanied tours and less troops, or unaccompanied tours and more troops, which would you favor?

Sergeant SOMMERS. Sir, I would favor the unaccompanied tours only because our forward deployed units, located in Okinawa, are the ones that we are dealing with in the Marine Corps. To cut down the number of unaccompanied tours over there would detract from our mission. I would say definitely not reduce the numbers.

Chief BUSHEY. Sir, I think for the Navy, we are just about at bare bone minimum now overseas. So I think if we cut any numbers, we are going to hurt our mission drastically. We are barely hanging in there in some of our support facilities overseas.

If you take any more accompanied tours away from us, and I am talking stateside or overseas, I think I am going to have a drastic retention problem.

For some it is the only opportunity they have to look to forward to. Some of our ratings are very sea-intensive. The only opportunity they are going to have to spend some time with their families is some of those overseas sites.

We have already lost some of our training command billets by civilianizing contract maintenance. That has been done internally to meet end strength restriction. Some of our aviation squadrons have seen billet reductions. So the shore duty billets where you can spend time with your family, are very limited.

And I think it would hurt our retention if we went either way. We are just about at the minimum we can go right now.

Sergeant Major GATES Sir, there is another side to this area, and one that I think that the leadership should consider. If we have unaccompanied tours overseas, due to the free access to the countries where our soldiers are stationed, some, or a large number of the family members would accompany those soldiers whether we authorized it or not. Because we do not have the authority to prevent them from purchasing an airline ticket and flying to Germany to spend a year or 18 months with their husband or their wife, whichever the case may be.

After the spouse and the families arrive in country, if we cut back on the facilities—medical and quality of life facilities—certainly we would have difficulties in taking care of those families because the programs they need would not be there.

We do have a moral obligation to take care of those Americans the best way we can if they arrive there as unauthorized dependents.

If I had the choice, I would consider units instead of the dependents.

ALL-VOLUNTEER FORCES

Senator STEVENS. I think we are getting to the point where we are going to have to make some really tough decisions. Senator Goldwater and I were among the first to suggest that we do away with the draft. But we are going to get back to the decision soon as to whether we can afford to maintain our modernization and our research and development and maintain the force levels that many people feel are necessary, and the policies such as the accompanied tours.

I remember going overseas during the period of the draft with Senator Hollings, into Germany and seeing a lot of the young people there in the Army, Sergeant Major Gates, that had done just what you said. They were not permitted to have families with them. And they were living off-base in third and fourth floor walkup cold-water flats with one gas burner and one electric light, and no medical attention.

And, I think, to a great extent, visits like that led to a change in policies of accompanied tours. Accompanied tours, as far as those areas were restored after we did away with the draft.

But it may well be that we have got some tougher issues ahead of us than most people believe as we look at this.

One of you mentioned that the—I guess all of you mentioned—the priority of keeping trained people in the service. And yet, we seem to have the same policies, personnelwise, for people who are going to make a career of the service and those who are just in for a very short period of time.

Have any of you examined the idea of having a short-term active service, plus, a commitment to the Reserve and having those who have a career commitment have a different type of personnel policy applied to them?

Do you understand what I am saying? Could we have an enlistment policy, when you come in and enlist and say, "I am a career person, I am going to spend more than x number of years in the service," or, "I am just going to go in and serve 6 months and then I am going to go in the Reserves; and my major connection with the military is going to be in the Reserve or National Guard on a nonactive basis"?

Could we develop a new policy that would lead us to a two-tier personnel system in peacetime and have it avoid the necessity of reviewing the concepts of the draft again?

Chief BUSHEY. Well, I will try to tackle that one, although I will be very careful. I think that is something I would want to sit back and study in depth, and you are talking about going back to almost the way it was when I came in.

There was a definite break between the time you were considered a careerist and the benefits you got, even the pay. I can remember going over 2 years and all of a sudden I could buy something instead of a popsicle and have to split it in half and share it with my wife. There was a big difference between the under 2

years and over 2 years. And when you were obligated to go over 4 years.

So if I look back at my own experience I'd say, yes, I would probably like that; that there should be a point when you are considered a careerist and the benefits would be different. So I think I would want to really look at that in depth.

I am not quite sure how that would affect our recruiting and how that would affect our retention.

Senator STEVENS. Does anyone else want to comment?

Sergeant Major GATES. Sir, I would just like to make a comment. But, before I do so, I would like to again, I do not know why I continue to echo you. Evidently, because we are good friends.

But the fact of the matter is, sir, we have a program very similar to that for our combat arms enlistees. We have a program where an individual can enlist for 2 years in the Army, but only in the combat arms and we are asking for similar consideration for soldiers to be allowed to enlist in the Army in the combat service support occupational specialties, where they would serve 2 years in the Active Force, 2 years in the U.S. Army Reserve in a troop unit, and then have 4 years in the Individual Ready Reserve.

Senator STEVENS. If I could interrupt. You do not say if you are in for 2 years you cannot have your dependents with you and you are going to get different allowances? You have not done that? We have not legislated that, anyway.

Sergeant Major GATES. No, sir. We have not considered, to my knowledge, that part of the program.

Chief BINNICKER. Thirty-two years ago, Senator Stevens, if I would have been forced to make a decision when I came in the Air Force to sign up for a career or for whatever the other alternative might be called, I would not be sitting here today.

I came in the Air Force 32 years ago, not with the idea in mind of staying 32 years, going career or anything else. I came in with a chip on my shoulder and I was really unhappy with the whole world.

At some point, I guess some long-striper kicked me in the butt and turned me around. And here I am.

Senator STEVENS. Well, 32 years ago, you did not have the pay and allowances as an enlistee that you have today, either. You did not have accompanied tour privileges, either.

Chief BINNICKER. No, sir; I did not have a car. I lived in the barracks. I worked parttime as a dishwasher to even make ends meet on that salary being single.

CONFLICT BETWEEN PERSONNEL POLICIES AND MODERNIZATION AND PLANS

Senator STEVENS.—Mr. Chairman, perhaps I am being too serious about this, but I think we ought to get serious. I really see a funding conflict coming between modernization plans and personnel policies.

And we have some real hard decisions to make. And I think that the enlisted people ought to be involved in those decisions. It seems to me that if you look at now compared to the time when Senator Mansfield offered his resolution to require us to bring half our

troops home from Europe, there were a little more than 250,000 troops there then. There are over 330,000 troops there now, not counting the Navy.

And when you look at that troop commitment to Europe, with dependents and with all of the costs associated with dependents—and I am not criticizing, I am just saying as a matter of fact they are there—we have a tough decision to make. Can we continue to afford that many troops with dependents? And what should we do?

That is primarily an Army commitment and, increasingly, Air Force. I do think that we have to have some real thinking from some of your people as to what is fair. And it ought not to be just the commissioned officer corps that tells us what is fair. I think that, to a great extent, these are some of the issues we ought to think about with you.

Chief BINNICKER. I agree with you, sir, that there are some tough decisions that are forthcoming. And I am not smart enough to tell you or anyone else where the balance is in force modernization and how many people should be forward deployed.

But I do know that any decision we make in personnel policies, I would request that they be balanced. And I appreciate your suggestion that we be involved in the decision process.

Because that decision has to be balanced with all the other things that are impacting our folks in a negative way, not just personnel policies, but medical care and all the other things that other people, other committees are looking at that will take away from the overall attitude of military life is what I want to do.

VARIABLE HOUSING ALLOWANCE

Senator STEVENS. Let me go into one other subject before I leave, Mr. Chairman. And that is VHA. When the Department decided to go the route of variable housing allowance [VHA], I objected. At the time, I was chairman of the subcommittee, I felt that there would be a real difficult time for people in the service if we reached a point when housing costs started going down.

Nationally, they have not gone down, but in particular areas such as mine and some of the other areas generally affected by the oil industry and a few others that have had difficulties, we have had a series of reevaluations of properties and a decline in VHA payments, notwithstanding the fact that the people who are occupying those homes are still paying the higher prices.

Now, I understand Chief Binnicker, in your testimony, you indicated that VHA was reduced for 68 percent of Air Force recipients. Was that primarily in the areas that I described, where they have Texas, Louisiana, California, Alaska, places that have been affected by the decline in oil prices and the economy has been shot?

Chief BINNICKER. Yes, sir, primarily.

Senator STEVENS. But those people are still paying the same prices for the homes they occupy; is that right?

Chief BINNICKER. That is the analogy I use. The E-6 in Anchorage is paying \$1,000 a month rent. The local median housing cost went down, his rent did not go down, but his VHA was cut \$105 a month.

Senator STEVENS. He's probably got an empty house on both sides of him. He cannot move into those because he is obligated in the house he is in.

Chief BINNICKER. That is right. We gave him a 4-percent pay raise, we raised his BAQ by 7 percent, and then we take \$105 a month away from him. And I can explain to people why they do not get a pay raise, I can explain why they do not get a raise in VHA, but what I cannot get my hands around is how do you lose money when your rent did not go down.

Senator STEVENS. I really think we need to have some investigation of that, because I think it is a very unfair system. It does not meet the needs of people when the cost of housing around them goes down, and theirs does not.

Now the other system had equally some defects, I might add. Neither one of them were perfect, but in areas of declining property values, the VHA system has performed as we anticipated, and it has been very unfair.

Thank you, Mr. Chairman.

Senator INOUE. Thank you.

Senator SPECTER.

Senator SPECTER. Thank you, Mr. Chairman.

Just a question or two.

First, I would note the very excellent statements, which have been submitted. I would say this distinguished array of witnesses is a very impressive one, the enlisted personnel issues. I have not seen so many stripes in anyone sitting in my brief tenure here.

MORALE OF THE TROOPS

One question which I have is the status of morale at the present time compared to what it was, say, 5, 8, 10 years ago. There has been a real effort made by the Congress, the Government, to increase pay and try to make it more attractive to stay in the service.

Have we been successful or partially successful in that? What would you say is the quality of the morale among enlisted personnel today compared with 5 years ago, 8 years ago?

Sergeant Major GATES. Sir, I can talk about that for hours. I believe that the morale and esprit de corps of our soldiers have blossomed over the last 5 to 6 years because of the increase in the concerns for the quality of life issues, not only for the soldiers, but for their family members.

And, ironically enough, the nearer those soldiers are to the threat, the higher the morale and esprit has a tendency to be, such as the soldiers stationed along the DMZ in Korea.

Their morale and esprit is extremely high. But I believe we have a way to go in our quality of life program, because we still have many, many soldiers, about 40,000 of them, living in inadequate quarters. And not only single soldiers, but married soldiers.

Chief BUSHEY. I think the morale in the Navy has never been better and I think you can tie that all together. It is not just a compensation issue and a quality of life issue, it is also an operational issue.

Morale in the Navy gets very, very low when your ship is tied up to the pier or your airplane is sitting on the ramp. You just spent 3 days working on the airplane, but now, for lack of parts you cannot get it in the air. Our real reward is task oriented. When we see an airplane go off the bow of the ship, we have done a good job and we feel good about that.

When we get a ship underway and we were able to have the parts to fix it, we feel good about that. And so I think you have got to lump it all together. The quality of life issues, they know we are out there working hard for them.

There is a long way to go on the quality of life, but that has been part of it. I ask a lot of them why do they stay, it is because they believe in what they are doing. They enjoy what they are doing.

As you noticed I put in my statement, I think we have a lot of fencewalkers. There are a lot of them right now that are just to the breaking point, waiting to see just how much more is going to be taken away. When we start talking about the medical program, retirement system, the pay, the inequities in VHA and COLA on, I believe it is how we do those surveys. If you put all that together right, they will stay because they want to stay, but the job market on the outside is going to drag them away from us if we don't.

There is just too much available on the outside right now to put up with the sacrifices you have to put up with in the sea services. So we have got to be very careful on that part.

Morale, right now, is still very, very high. And that is because of the quality people we have.

Senator SPECTER. It is a pretty tough, competitive market out there, with labor shortages in so many parts of the country. You have got a lot of competition.

Chief BUSHEY. Yes, sir. As a matter of fact, when I talked to the House side I related the story where I sat on an airliner beside an individual who was a personnel manager for a company.

And he was telling me the problems he was having hiring quality people. It happened to be a paper mill. And he said we have gone from the brawns to the brains. Now, when we hire people, we have to keep them. Everything is computerized. And we spend a lot of money training them. I cannot afford to hire somebody that is only going to stay with me 6 months or a year, and I just cannot find that quality coming out of high school. I thought I was sitting next to a Navy recruiter.

Sergeant SOMMERS. Sir, I believe the morale of our Marines is great. Their morale, like their Navy counterparts, is at the highest when they have the parts and equipment to do what they are told to do.

We continually talk about the quality of life issue and I think Senator Stevens hit the nail right smack on the head. We continually address the problems of quality of life, but we never address the source of the problem. The source of the problem today in the Marine Corps is the number of dependents we have. We have got 197,200 Marines and 224,000-plus dependents. We are outnumbered by our dependents. It is my belief, and it is a very strong belief, that a Marine should not be allowed to enlist in the Marine Corps with a ready-made family. We should not take a Marine that already has a family.

There was a time when we had to ask our commanding officer for permission to get married. He, like any good father, would go over the individual's financial capabilities to see if he could, in fact, support a family.

Senator SPECTER. So he had to ask?

Sergeant SOMMERS. Yes, sir. He would talk to the young man and go over his financial responsibility with him and determine whether he could, in fact, support a family. Today, we make it very easy for a young man or woman to come in the Marine Corps with a family, because we are going to take care of them. They have become our responsibility. That family becomes the responsibility of that commanding officer and that battalion sergeant major. They are directly responsible for that family.

They, in turn, will try and make sure that that family has housing and proper medical care and all the things that go with it. I do not know if we could do it in this day and age, but I would not allow a Marine to have his dependents with him for the first 4 years that he is on active duty. He would take the leave and do that sort of thing, but when we go to a forward-deployed area, the dependents become a problem. They really do. That is the source of the problem.

I do not want to sound like I am against marriage and all that sort of thing; I am not. But when it comes to being able to perform our mission, and considering the moneys we are required to use in family support, it becomes a very sore issue with me because every dollar that goes toward the support of families and dependents detracts from something that may keep one of my Marines alive.

I do not know how else to put it. It is not a very pleasant subject. It is one that has plagued the services and I just think it needs a very hardball approach. I am sure that I would probably get booted out of the arena if I made that statement in a division gathering, but it needs to be addressed. I think, Senator Stevens, talking about it right up front, saying we need to do something about the issue and do something about it very quickly is a very, very true hardball statement.

POMCUS UNITS IN EUROPE

Senator STEVENS. Would you yield just for a second right there.

Sergeant Major Sommers, when we went to look at the POMCUS units in Europe and we asked the commanding general what was his first task in the event of an attack on a POMCUS unit, and he told us his first task was to organize the dependents to get them ready to leave on the first plane that brought in the people that were going to use that prepositioned equipment.

This is not just your problem, it is the Army's problem and everyone else's problem in the event of war. We are not living on the basis of really planning in the event of war any longer. Because we do, in fact, have an extended dependent policy and it is one of the greatest complications in the event of war we face.

And you are right. You would get shouted right out of town if you mentioned the subject.

Sergeant SOMMERS. Sir, if I may add to that, our families do a superb job on the home front. The wives do a magnificent job keep-

ing the younger families together and making sure they are taken care of. But it is an issue, and with the dwindling resources, I believe that it is going to have to be confronted very soon.

Senator SPECTER. Well, Sergeant Major Sommers, if you put into effect a policy of not having any dependents for the first 4 years, you certainly would discourage that type of personnel. And some of the things you said here today may get out anyway.

Sergeant SOMMERS. Sir, it may certainly discourage some, but I think we try to sell, sometimes, in the recruiting arena, maybe too many benefits for our young people, and we make it too easy for them to have dependents.

Senator SPECTER. Chief Master Sergeant Binnicker, would you care to comment on that issue?

Chief BINNICKER. Yes, sir; I agree that that would be a great program for the Marine Corps. [Laughter.]

But I do not think it would wash in the Air Force. Going back to the original question of morale, I think the morale is at an all-time high. I would have to say, though, that following that end of statement I would have to put, "but comma." And there are a lot of folks that are looking at that dark cloud that I alluded to in my opening comments, that dark cloud on the horizon, of uncertainty of what the future holds.

So we enjoy good morale now, which talks to our good retention and ability to recruit the highest quality that America has to offer. But I am not sure what next year is going to bring.

GI BILL OF RIGHTS

Senator SPECTER. I have just one other question, Mr. Chairman. And I have just one comment on this, and that is, to what extent does the GI bill of Rights for assistance on education have in inducing people to enlist, in your opinion?

Sergeant Major Gates, would you respond to that?

Sergeant Major GATES. Sir, since we have adopted the GI bill, we have had very good success with our recruiting. And that has caused us to be able to recruit quality soldiers into our Army.

We strongly believe that not only does it have an effect on the quality of young men and women who enlist in the Army, but it certainly will have an effect on our country in the long run.

Because these young men and women can spend a period of time in the Army and then leave, attend college, and certainly they become more informed and better educated citizens of our country.

Senator SPECTER. Thank you very much.

Thank you, Mr. Chairman.

Senator INOUE. Thank you very much.

As Senator Stevens suggested, we will be having many problems relating to the budget. And that is our problem. And I will not insult you by asking questions such as, should we cut the left foot off or the right foot off. That is for us to decide. Although we may be tempted to ask you, should we support peoples' programs or modernization. And I think we should be concerned about both of them.

MEDICAL CARE SATISFACTION

But let's touch upon a few more peoples' programs. Are the men and women satisfied with medical care?

Chief BINNICKER. I think they are satisfied with the medical care when they receive it. We have the best doctors in the world, the best medicine in the world. The problem is there is a shortage of specialties in areas. And, therefore, the wait becomes longer. CHAMPUS and other alternatives must be used.

And so I would say that they are happy with the medical care that they get, but it is the fact that they do not have enough to go around. And the idea of a user fee, as I indicated in my opening statement, runs against everything we stand for.

Senator INOUE. Sergeant Major.

Sergeant SOMMERS. Sir, we have a problem with medical care. We are seeing some improvements over this last year, and I use as an example the hospital at Camp Lejeune. The Navy has made a strong effort to square away the Camp Lejeune Hospital, but we still have a large number of the young families that have to deal with CHAMPUS. The problem that we are encountering along with the problems of shortage of medical personnel is the dwindling number of doctors that are accepting CHAMPUS payments because of the delays in processing CHAMPUS claims. The shortage of doctors is becoming a significant problem as well. I would like to pass to the MCPON, because he and I have discussed the Navy medical care issue frequently, and I am sure he has better comments and better answers in that area.

Senator INOUE. We were concerned about Navy medical services and, as you know, last year we appropriated about \$90 million more than requested for Navy medical. I do not know if that has shown any improvement.

Chief BUSHEY. Well, in recent years there have been some major improvements. I think the answer to the question was heard in the back of the room with the chuckles and the groans.

We have made some big mistakes in the Navy medical program, and it has not been the quality, it has been the quantity.

And I think in years past the decision was made, "Well, we will take care of the active duty and we will put the retired and the dependents out on the economy and into the CHAMPUS program."

We found out that was a terrible mistake. I do not know who made that decision, but I think he is taking a lot of heat right now, and we have reversed that now and we have got to go back and bring our dependents back in. They are part of our retention. They are our family, and we need them in our Navy medical system to keep the medical system going.

And I think what we need now is to put support in. How do we keep doctors? We have got to keep the internship program going and we have got to fund that properly. We are making a lot of fixes now, but our doctors are still leaving faster than we can bring them in.

The blue ribbon panel has done the right things. They made some suggestions; they have stirred the pot. Bethesda—I had the misfortune, I guess, to go see that personally with a bad case of pneumonia in the month of January, and so I spent a lot of time

laying in bed and talking to doctors and talking to nurses, and they feel like we are going in the right direction, and things are coming up.

We have also learned how to use our corpsmen better; our independent duty corpsmen that will help take the workload off of some of our doctors. We have got to fix that. I think it is also—the demand for the medical has been more because of the spouses having to work.

And if you would picture just trying to be unable to survive as a senior enlisted, and I am talking about E-5 or E-6. Now, in a lot of areas the spouse has to work not for the niceties, but to help put food on the table. And then when your young ones get sick, the child care will not take them and then you spend half a day sitting down there waiting to get into the Navy medical system or going around to find a doctor that will take CHAMPUS. That has a negative impact on us.

Senator INOUE. Sergeant Major Gates.

Sergeant Major GATES. Sir, first I would like to comment about the proposed user fee at our military facilities. Our soldiers consider that a nuisance fee. They really do not understand the purpose of the fee and what it will accomplish in the long run. That \$5 the soldier must pay for dependents to visit a military facility, they cannot visualize it having any effect on increasing the size of that facility or increasing the staffing that is required in our facilities.

The quality of the medical care is as good in our military facilities as it is anywhere else in the world, and probably better. The problem is the size of the facilities and the staffing. And I would say very clearly, that our soldiers in many, many cases are confused over the CHAMPUS program, and they have to pay large amounts of dollars out of their pockets for the CHAMPUS program.

I suggested that if a hard look were made at the \$2½ billion that we expend yearly in the CHAMPUS program, that probably some of that money could be funneled back into our military facilities to acquire additional staffing for our great doctors and corpsmen.

There is a success story in some of our medical programs, sir. The dental program is a success. It is one of the best programs that we have seen and adopted over the year. The primary medical care clinics are a success, and we certainly appreciate that, and we continue to appreciate your support in providing proper and top quality care for our soldiers.

CHAMPUS

Senator INOUE. We have been looking into CHAMPUS. For example, since 1985 it has gone up 70 percent, and since its inception it has quadrupled.

A very simple question: Do the men and women in your units look upon medical care, retirement pay as part of a contract with the Government of the United States?

Chief BUSHEY. Yes, sir. When we join—I certainly felt that way when I joined, that was part of my benefits and that was part of my long-range plan.

I would like to also add that our sailors are very aware, too, that if they stay in for 20 years, what is this medical plan going to be in my retirement. So, they watch very carefully how we treat our retirees and our medical system and also the caps on the retired pay.

Senator INOUE. I suppose all of you agree?

Sergeant Major GATES. Sir, I believe that our soldiers deserve a method of being able to predict their future if they are going to remain in the Army and use the Army as a career. A soldier should be able to sort of predict when they will be promoted.

They should be able to predict what benefit packages are available to them during their active duty years, and the package that will be available to them after retirement. And, in some form, these packages should remain consistent.

Senator INOUE. According to the Pentagon, the most recent numbers, noncoms in the top five pay grades account for 41.6 percent of the enlisted in the Army, 45.5 percent in the Navy, 48 percent in the Air Force, and 31½ in the Marine Corps. Do you think this is a proper ratio?

Chief BINNICKER. Well, since I am the highest, I will go first.

I think the 48 percent is, according to the last statistics I looked at, about 4 percent below what we really need. So if we had what we really needed, based upon mission requirements, it would be 51 percent. But I think that the 48 percent is appropriate in today's high tech Air Force, and we need that kind of experience and leadership that will take us through any other programmatic changes that might occur. But I think it is appropriate at this point.

Senator INOUE. The Marines have what they call a perfect pyramid for NCO strength.

Sergeant SOMMERS. Sir, the pyramid structure for the promotion system, which allows more privates than sergeants major, is designed to show an individual his promotional opportunities. General Gray has in the last 1½ years thrust in that direction to try and get this promotion business squared away. An individual coming in the Marine Corps will be able to look at the long-range plan and know that if he is qualified and chooses to stay in the Marine Corps, that he can obtain the rank of master sergeant within a 22-year timeframe. That is the long-range goal.

We feel that it will take anywhere from 3 to 5 years to get this pyramid structure in the system, and we are doing very well at it as evidenced by the increased promotions this year, sir.

Chief BUSHEY. Senator, I am pretty happy with the system we have. Right now at the senior enlisted level, the E-9 level, it is only 1.8 percent of the total force, which is a good figure in our balance.

When you figure the noncom, you are going all the way down to the third class petty officer, the E-4 level, and that is where the bulk of that drives it up to make it look like it is a high figure. But when you start getting up into the E-7, the chief petty officer level, E-8 and E-9, we are very well balanced.

I think, also, if you look at the Navy service, our officer to enlistee ratio is much less than other services. I believe the figure—and I would have to look this up—is 7 to 1, which has put more responsibility down on the senior enlisted at our chief petty officer level

as where it should be and where we can take care of our people the best.

We have a very good balance right now. It is also very, very much of a retention issue, too. An individual that joins the Navy ought to be able to look at reaching the chief petty officer level in a 20-22 year career. If they cannot, a lot of them give up at the 6 to 8 year mark and leave us.

Senator INOUE. Sergeant Major.

Sergeant Major GATES. Sir, we believe that we need to consider the ratio of noncommissioned officers compared to lower ranking soldiers. During mobilization what will happen to the force is one factor that I believe we should strongly consider.

The Army has many technical fields that require noncommissioned officers such as logistics, in some cases very technical, and in order for a soldier to stay in that field or remain in that field for a career of 20 years or more, then certainly that soldier should have an opportunity to be promoted.

And so, I believe we have got to consider the entire ball of wax, if you will, when we are considering the ratio of NCO's in comparison to the young soldier.

MILITARY ADVERTISING

Senator INOUE. In the matter of recruiting we do a lot of advertising. The DOD is requesting \$124,399,000 for all the services, plus \$33 million for the joint program. Do you believe the service-specific advertising produces better results than a more general joint approach?

Chief BUSHEY. I would like to jump on that one pretty quickly because I feel in the Navy we have a particular problem there in the public, and the young men and women today do not understand the mission of the Navy. That is a result of a survey we just went out and took.

We asked them, what do you think about when you think of each one of the services, and when it got to the Navy side, they really did not have anything positive to say. Long deployments, long times at sea, lonesomeness, and nontechnical, which is totally wrong. We are not projecting the right image to our community at all when it comes to advertising for the Navy.

Senator INOUE. So, you want service-specific?

Chief BUSHEY. Yes, sir.

Sergeant Major GATES. Sir, I believe the services, the different services analyze and can come up with plans to best suit their services as far as recruiting. We know what the requirements are, and we need to have the tools in order to target that sector of our society in order to recruit quality soldiers into our Army.

All the services have a responsibility to defend this country, and our allies during time of war. But, sir, we are different branches of the service, and I believe that we should target the recruiting to the services.

Senator INOUE. Is there any disagreement?

Chief BINNICKER. Service-specific.

Sergeant SOMMERS. I agree, sir.

Senator INOUE. Then we just may do away with the joint program and split it up among you four fellows.

Sergeant Major GATES. I would like, if I may, please, sir, one last comment.

A young private first class at Fort Benning, GA, had the opportunity to see one of the joint services recruiting advertisements during one of the football games. And he made the effort of calling me and telling me that we did not properly represent the U.S. Army in that recruiting scheme. And he was exactly right.

I went back and reviewed the film, and we felt that we were sort of shortchanged. No reflection on anyone, sir, but I believe we can better use the money.

RECRUITING SCANDAL

Senator INOUE. Well, over the years we have had reports in the press of recruiting scandals, of certain quotas that have to be met, so recruiting personnel have rigged up diplomas and such. Have we brought these things under control? The Marines just had one recently, I think.

Sergeant SOMMERS. Yes, sir; we did. Unfortunately that whole activity was initiated by a recruiter who was sent out there to ensure that sort of thing did not happen. We caught the problem as soon as it was discovered. We sent an investigative team out, which resulted in a large number of Marines being relieved of duties to include recruits being dropped from recruit training and others being dropped out of the pipeline.

I have to say that my Commandant has made a great effort in the recruiting area to ensure that pressures are relieved from the recruiting system. When a Marine goes into recruiting—and I am sure the other services are very similar—when he goes to quota he needs to be productive. He needs to make his mission. He needs to be productive and show that he is doing what he is sent out there to do. It is the Commandant's belief that everybody cannot be a recruiter. We were taking these Marines and saying, "You are going to be a recruiter, and this is what you are going to do," and we would leave them there. It was a sink-or-swim mentality.

The Commandant has relieved recruiting of that pressure and he has told them that if a Marine is not doing well in recruiting and if he is failing because he just does not have the ability to be a good recruiter, then he should be moved from the recruiting force and sent back to his occupational specialty.

I believe when this takes full effect and gets a good hold in the system, this will greatly help in alleviating any sort of problems such as this. But this is one of those unfortunate incidents that luckily we caught before it went too far. I might add if this group would have made it into the pipeline, recruit training at the Recruit Training Regiment at San Diego or Paris Island would have eventually caught these individuals because of social security numbers and the safeguards and checks and balances that we have in the system. It is unfortunate we did not catch it before it got this far, sir.

Senator INOUE. Do others have it under control?

Chief BUSHEY. Yes, sir. I think I am very proud of what we have done recently in the Navy in the recruiting business, and I think a lot of credit can go right from the CNO, the Vice CNO, right on down.

Admiral Boorda, our Chief of Naval Personnel, came in very, very strong on how we would treat our recruiters. Recruiting duty is probably the toughest duty you can get in the U.S. Navy, and it is uncomfortable for us. It is like the fish being out of the water.

We put a lot of pressure on those men and women we put on recruiting duty. I think in years back we civilianized it where it became a business and a no-go. You survive or you fail. That put a lot of pressure on them.

That has been turned around. We now have a chief recruiter, Rear Admiral McKinnon, that has put in a new quality of life program that is going to prevent—not to say some things still cannot happen, but the quality of life for the recruiters that I have seen has greatly improved. That was another one of my personal goals coming in; to improve quality of life for recruiters and that a young man or woman could come from sea duty, go to recruiting duty, and leave there with a good feeling.

Sergeant Major GATES. Sir, we have policed our recruiting force to the point where we do not have an overabundance of those incidents.

I think as long as we have a dwindling market of available manpower to recruit from and if we do not supply our great outstanding noncommissioned officers with the tools needed to attract quality soldiers and having applied the pressure of a quota onto them, then we may very well see some additional incidents pop up.

But we have taken measures to prevent those recruiting irregularities. We have increased the quality of life for these soldiers that are on recruiting duty and we have ensured that their career progression is continued even though they are not working in their primary duty.

Chief BINNICKER. I think it is under control in the Air Force, Senator. And, like the Marine Corps, if we had a case, it would be an isolated incident that we would deal with it in a very swift manner.

Chief BUSHEY. Sir, could I make one more comment because I met with a large group of recruiters yesterday here from the Washington, DC, district, and I heard the same things that I hear all around as I talk to recruiters.

One is that, because of the lack of dollars in recruiting, they are still paying a lot of out-of-pocket expenses. It costs a sailor to go to recruiting duty out of his own pocket.

The second thing is the Dep program. They have a problem with a young man or woman coming in and raising their hand and swearing on the Bible that they will come in the Navy and swear their country and then 6 months later when they are called up saying, "No, I changed my mind," and there is really nothing we can hold them to. We have a double swearing in system, and that is by law right now, and they are asking for help with that.

They do not think it is right that somebody could commit to join and then be able to change their mind 6 months later, that there ought to be a definite commitment.

WOMEN IN UNIFORM

Senator INOUE. Overall we have about 10 percent of the personnel being women, most in the Army and the Air Force, less in the Marines and the Navy. Do you think it was a good policy on the part of the decisionmakers to involve women in our uniformed services?

Chief BINNICKER. Yes, sir. we have 13 percent in the Air Force. Currently, Air Force policy prohibits women from entering skills exposing them to direct combat, hostile fire, or capture. This reflects the full intent of the combat exclusion law and the will of the American people.

They serve everywhere around the world and in almost—well, all but four specialties, and are very proud of the progress they are making. About 5 years ago we only had 12 female E-9 chief master sergeants. Today we have 40, and that is not as a result of us going around looking for women to promote, but because they excelled and got promoted in their own right. So, I think it was an excellent decision.

Sergeant SOMMERS. Sir, our women in the Marine Corps are doing very well. We would not be able to boast the readiness and the deployment schedules that we presently have without our women Marines. They excel in most every area that we place them. We, too, do not have them in the direct combat areas. They are in all our combat service support units and if a unit deploys, they, too, will deploy. They will not go aboard ship. They will be flown in.

In the next conflict that we have, women Marines are going to be directly involved in it. They are going to be directly in it because of their assignment to these support billets. I am sure, because of their training, that they will handle themselves very well. But I believe that society needs to take note that for the women Marines who are serving in combat service support and communication areas, there are no rear areas. Women Marines are going to become engaged in combat, and I believe that society should be prepared for his and her body bags. We will take women casualties along with everyone else.

Our women Marines are doing a superb job and not one of them would come here and tell you that they would not fight along with their male counterparts. They do a superb job and we are very, very proud of our women.

Chief BUSHEY. Without any hesitation at all I would say it was the right decision. In fact, I think bringing women into the Navy, putting them in the roles we did, is why we have the quality we have today.

I was fortunate to serve in one of the first squadrons that received females. We had problems in the beginning because we had to learn. We learned and our quality went up.

When I was wing command master chief and had 12 squadrons, one of those squadrons was 40-percent manned with women. It went from being our bottom squadron to our top squadron because of the competition that the females brought to us.

I think we have got to look very close at our law that does not allow them to serve in all positions. Yes, we will have his and her

body bags. It is here now. It is already here. We have them on Sea-lift ships; we have them flying our aircraft. We are all targets, no matter where we are located. There is no front line anymore.

Sergeant Major GATES. Sir, I would like to say that about 11 percent of our Army is women, and those women are performing in an outstanding manner, exactly at the same standards as their male counterparts and we are having absolutely no problem with our women serving in our great Army.

About 87 percent of our enlisted specialties are open to women. They are precluded from serving in units where there is a direct combat probability. They are doing a good job.

Again, I think that our society should be prepared if we have a future conflict to accept women becoming casualties on the battlefield.

Senator INOUE. Do you think the services could have met the recruiting goals without women?

Chief BUSHEY. No.

Senator INOUE. I suppose that is the answer from all of you.

Sergeant SOMMERS. We have such a small number, sir, I am not sure whether we would have met that goal or not. As you well know, we have much fewer women than the other services.

Senator INOUE. Over the following weeks and months, this committee will be visiting with fellow enlisted personnel. We will be meeting with them, asking them questions, and asking them for their suggestions and recommendations. I would like to thank all of you on behalf of the subcommittee for your presentation this morning. I think your fellow enlisted men and women can be very proud of all of you, Chief Binnicker, Sergeant Major Sommers, Chief Bushey, and Sergeant Major Gates. I am very proud to say that I put on a uniform once upon a time. You guys are all right.

Chief BUSHEY. Mr. Chairman, could I ask you one more thing for a small group? It is a quality of life issue for mainly 6,000 people, but there is a bill in right now, H.R. 2383, that deals with the Filipinos who joined in the Philippines after October 1978. They can serve this country faithfully for 20 years, retire, but cannot become U.S. citizens, and I would beg this committee's support to look into that and correct that wrong.

Senator INOUE. In fact, I am trying to go a step further. There are many men who served us in uniform during World War II, who risked their lives and served under our command and discipline. The least we can do is to recognize their service. They are not asking for any benefits of citizenship or otherwise. I hope that this Congress will see fit to grant them the honor that is long overdue.

Once again, I thank you all and I can assure you that we will be looking into the pay matter and the quality of life issues. I can assure you, we will not cut your legs off. Thank you very much.

Now we will hear from Mrs. Sydney Hickey, of the National Military Family Association, and Sgt. Maj. C.A. (Mack) McKinney of the Noncommissioned Officers Association.

Mrs. Hickey, Sergeant Major McKinney, welcome.

Mrs. Hickey, would you like to proceed?

STATEMENT OF MRS. SYDNEY T. HICKEY, DIRECTOR OF GOVERNMENT
RELATIONS, NATIONAL MILITARY FAMILY ASSOCIATION, INC.

MILITARY FAMILIES APPREHENSIVE

Mrs. HICKEY. Thank you, Mr. Chairman.

Mr. Chairman, the National Military Family Association appreciates this opportunity to express its views. Military families of today are apprehensive about their future. They need the assurance of a certain amount of stability in their lives. They need to know that they will not have another cut in take-home pay. They must have the assurance that, barring a general economic decline in the United States, they can purchase tomorrow what they can buy today.

They need the assurance that their out-of-pocket expenses will not fluctuate widely every time they move, and will stabilize at the 15 percent mandated by Congress. They need the assurance that promised medical care will be available today and tomorrow. They need the assurance of continued savings at the commissary and the exchange, and the assurance that the recreational opportunities offered on post will not be out of their family's budget.

They need the assurance that given good performance, the military member can count on a career, if so desired, and not be subject to arbitrary, budget-driven reductions in force. They need the assurance that earned promotions will not be unnecessarily delayed.

They need the assurance that unaccompanied assignments will be as few and as short as possible and that they would be mission-related and not budget-driven. They need the assurance that the retired pay and benefits promised at recruitment will be there at retirement.

Why does the military family think its stability is threatened? In 1989, a highly trained helicopter mechanic E-4 receives \$966 a month in base pay, which is 1.2 percent behind inflation and 10.5 percent behind the private sector.

His young family arrives at each new duty station \$1,000 to \$3,000 in debt because of unreimbursed permanent change of station and temporary lodging expenses. They are paying 21.5 percent of their housing cost, rather than the 15 percent envisioned by this Congress in legislation.

The price of on-post movies, bowling alleys, hobby shops and other recreational outlets have increased 40 to 100 percent. The fees for on-post child care have risen substantially and waiting lists are long. Drop-in care, whether for badly-needed respite care to prevent child abuse or for volunteer workers, is essentially unavailable.

MEDICAL CARE

Since access to medical care in the military treatment facility is limited for his family, the E-4 is forced to send them out on CHAMPUS. The CHAMPUS deductible for his family is \$100 a year and his co-payment approaches 30 to 40 percent, not the 20 percent mandated, because less than 50 percent of providers in this country will accept CHAMPUS assignment.

Military families have been authorized an extra month's dislocation allowance on PCS for 2 years. They have never received it. Military families who do not itemize on their Federal income tax are no longer able to deduct their unreimbursed PCS cost. Families overseas were suddenly forced to absorb unexpected and extremely costly CONUS transportation cost for their college students when the overseas student travel benefit was reduced.

This year's pay raise, substantial increase in basic allowance for quarters, and increased household goods weight allowance were greatly appreciated in the military community. However, the military family fears that next year they will have to pay for them through such things as forced family separations, user fees in military treatment facilities, and lost retirement benefits. The military family is well aware that the administration's budget provision includes a provision that would decrease the retired pay of an E-7 with 20 years service by well over \$34,000.

COMPETITION FROM PRIVATE SECTOR

The American business community is desperate for educated, trained, or equally important, trainable young people. This young helicopter mechanic, now highly trained, is a prime target for the airline industry.

They have offered him and his wife a free house hunting trip; they have offered to help him purchase a home in a decent neighborhood with excellent schools; they have offered to pay all of his moving expenses; they have offered to find his wife a job; they have offered subsidized child care.

They have offered a medical and dental insurance plan; they have offered an exceptional retirement plan; and they have offered him a very competitive salary with excellent opportunities for advancement.

However, our young military family is patriotic, and it is hard-working and it enjoys a challenge. They appreciate the camaraderie and adventure of service life. They value the experience of being part of a professional team.

They want to stay in the military, but the challenge of military life must be balanced with a certain assurance of stability. When the young soldier, sailor, marine, or airman makes a commitment to serve his country for 4 to 6 years, what is the country's commitment to him?

SPOUSAL EMPLOYMENT

NMFA suggests that the following initiatives could provide additional sources of income for the military family at relatively little expense to the government. In spousal employment: since approximately 60 percent of our military spouses are in the work force although they earn less than their civilian peers, those wives with children under 6 contribute more to their family income if they are military spouses.

They also have three times the unemployment rate and are substantially underemployed. Expanded referral networks to assist the family service center support counselor and a telephone job bank

such as the pilot program in Hampton Roads, VA, could markedly increase spousal employment.

Skill enhancement courses at family support centers and short-term skill-enhancing volunteer jobs with the Department of Defense and its agencies could increase the spouse's future earning power. Courses in portable careers and enhanced opportunities for home-based businesses on military installations could increase the spouse's chance for employment wherever the family is stationed.

CHILD CARE A NECESSITY

Affordable, dependable child care is a must for dual working couples. DOD states that a minimum of 80,000 additional child care spaces are needed now and MFA suggests subsidizing child care off-post. Several child care spaces in the civilian community could be paid for by DOD and military families would cost-share up to the level of fees at on-post child development centers.

Most military installations would suffer a severe blow to quality of life programs without volunteers. Drop-in child care is a necessity for volunteers. NMFA recommends that drop-in child care spaces should be a vital part of all military child-care programs.

Commissaries offer an extremely cost-effective benefit to military families. However, the majority of them have operating hours that make utilizing them difficult, if not impossible, for working families. NMFA suggests local surveys of all eligible patrons, not just those that walk through the door, of commissaries to ascertain hours of operation that would fit their needs, then meet those needs.

HEALTH CARE

Health care is often cited as the most important benefit of military life. Studies show that preventive care is extremely cost-effective, particularly for a population that continues to receive its care through the same system for several years.

NMFA suggests expanding the hours of primary care clinics to enable young working families to access this most important benefit. NMFA also suggests preventive health care and wellness programs be made available to all beneficiaries, not just the active duty.

NMFA suggests careful consideration of all current DOD health care demonstration projects. Unfortunately, these initiatives do not address the basic need for stability in the military compensation in the lives of our military families.

DOD is proposing several new initiatives for fiscal year 1990 to include extending the overseas student travel benefit to Alaska and Hawaii and payment for the storage of cars when service members are assigned to certain areas of the Pacific. These are long overdue benefits. However, it is NMFA's opinion that the stability factor must be addressed first.

Benefits that are inaccessible, unaffordable, and undependable are not benefits. Pay rates below inflation and inadequate housing allowances are not competitive compensation. Newspaper headlines threatening a reduction in the number of dependents overseas immediately translates into more family separations.

Military family members are familiar with family separations. They understand that the defense of the country must come first. They understand mission-related separations. They do not, and will not understand arbitrary budget decisions that will forcibly separate them.

Military family members are aware of the budget deficit. They are Americans, they are voters, they are taxpayers, they are volunteers who are willing to serve their country. But above all, they are people. They must have faith that those who make the decisions affecting their lives do care about them as people and do not just view them as pawns with which to balance the budget.

Thank you, Mr. Chairman.

[The statement follows:]

STATEMENT OF SYDNEY T. HICKEY, DIRECTOR OF GOVERNMENT RELATIONS, NATIONAL MILITARY FAMILY ASSOCIATION, INC.

The National Military Family Association (NMFA) is a volunteer organization composed of members from the seven uniformed services, active duty, retired and reserve, and their family members and survivors. NMFA is the only national organization whose sole focus is the military family and whose goal is to influence the development and implementation of policies which will improve the lives of those family members. NMFA appreciates this opportunity to express its views.

Military families of today are apprehensive about their future. They need the assurance of a certain amount of stability in their lives.

Stability of pay.—They need to know that they will not have another cut in take home pay. They must have the assurance that, barring a general economic decline in the United States, they can purchase tomorrow what they can purchase today.

Stability of housing costs.—They need the assurance that their out-of-pocket housing expenses will not fluctuate wildly every time they move and will stabilize at the 15% mandated by Congress.

Stability of the medical benefit.—They need the assurance that promised medical care will be available and accessible today and tomorrow.

Stability of other benefits.—They need the assurance of continued savings at the commissary and exchange and the assurance that recreational opportunities on post will not be priced out of their family budget.

Stability of military career.—They need the assurance that, given good performance, the military member can count on a career if so desired, and not be subject to arbitrary, budget driven Reductions in Force (RIFS). They need the assurance that earned promotions will not be unnecessarily delayed.

Stability of family life.—They need the assurance that unaccompanied assignments will be as few and as short as possible and that they are mission related and not budget driven.

Stability in the future.—They need the assurance that the retired pay and benefits promised at recruitment will be there at retirement.

Why does the military family think its stability is threatened?

In 1989, a highly trained helicopter mechanic, E-4, receives \$966.50 a month in base pay, 1.2% behind inflation and 10.5% behind the private sector. His young family arrives at each new duty station \$1,000.00 to \$3,000.00 in debt from unreimbursed costs of Permanent Change of Station (PCS) and temporary living expenses. They are paying 21.5% of their housing costs rather than the 15% envisioned by Congress in legislation. The price for on-post movies, bowling alleys, hobby shops and other recreational outlets have increased 40-100%. Fees for on-post child care have risen substantially and waiting lists are long. Drop-in care, whether for badly needed respite care or for volunteer workers, is essentially unavailable. Since access to medical care in a military treatment facility is limited for his family, the E-4 is forced to send them out on CHAMPUS. The CHAMPUS deductible for his family is \$100 a year and his copayment approaches 30-40%, since less than 50% of physicians accept CHAMPUS assignment.

Military families have been authorized an extra month's Dislocation Allowance (DLA) on PCS. They have never received it. Military families who do not itemize on their Federal income tax are no longer able to deduct their unreimbursed PCS costs. Families overseas were suddenly forced to absorb unexpected and extremely costly CONUS transportation for their college students when Overseas Student Travel

benefits were reduced. Last summer, families with teenagers, particularly those overseas, were greatly disturbed by the sudden drastic cutbacks in youth programs and youth employment opportunities.

This year's pay raise, substantial increase in Basic Allowance for Quarters (BAQ), and increased household goods weight allowances were greatly appreciated in the military community. However, the military family fears that next year they will have to pay for them through such things as forced family separations, user fees in military treatment facilities, and lost retirement benefits. The military family is well aware that the Administration's budget includes a provision that would decrease the retired pay of an E-7 with 20 years service by \$34,000.

The American business community is desperate for educated, trained or equally important, trainable young people. The young helicopter mechanic, now highly trained, is a prime target for the airline industry. They have offered him and his wife a free house hunting trip; they have offered to help him purchase a home in a decent neighborhood with excellent schools; they have offered to pay all his moving expenses; they have offered to help his wife find a job; they have offered subsidized child care; they have offered a medical and dental insurance plan; they have offered an exceptional retirement plan; and they have offered him a very competitive salary with excellent opportunities for advancement.

The young military family is patriotic, hard working, and enjoys challenge. They appreciate the camaraderie and adventure of service life. They value the experience of being part of a professional team. They want to stay in the military, but the challenge of military life must be balanced with a certain assurance of stability. When the young soldier, sailor, marine or airman makes a commitment to serve his country for four to 6 years, what is the country's commitment to him?

NMFA suggests that the following initiatives could provide additional sources of income for the military family at relatively little expense to the government.

SPOUSAL EMPLOYMENT

Approximately 60% of military spouses are in the work force. Although earning less than their civilian peers, those wives with children under the age of six contribute more to the family income. They also have three times the unemployment rate of their civilian counterparts and are substantially under employed. Expanded referral networks to assist the Family Support Center Employment Counselor and a telephone Job Bank such as the pilot program in Hampton Roads, Virginia, could markedly increase spousal employment. Skill enhancement courses at Family Support Centers and short term skill enhancing volunteer jobs with the Department of Defense (DOD) and its agencies could increase the spouse's future earning power. Courses in portable careers and enhanced opportunities for home based businesses on military installations could increase the spouses' chance for employment wherever the family is stationed.

Affordable, dependable child care is a must for dual working couples. DOD states that a minimum of 80,000 additional child care spaces are needed now. NMFA suggests subsidizing child care off-post. Several child care spaces in the civilian community could be "paid for" by DOD, and military families would cost-share up to the level of fees at post Child Development Centers.

VOLUNTEERS

Most military installations would suffer a severe blow to quality of life programs without volunteers. Drop-in child care is also a necessity for volunteers. NMFA suggests that drop-in child care spaces should be a vital part of military child care programs.

COMMISSARY

Commissaries offer an extremely cost effective benefit to military families. However, the majority of them have operating hours that make utilizing them difficult, if not impossible for working families. NMFA suggests local surveys of all eligible patrons of commissaries to ascertain hours of operation that would fit their needs. Then, meet those needs.

HEALTH CARE

Health care is often cited as the most important benefit of military life. Studies show that preventive health care is extremely cost effective, particularly for a population that continues to receive its care through the same system for several years. NMFA suggests expanding the hours of primary care clinics to enable young work-

ing families access to this important benefit. NMFA also suggests preventive health care and wellness programs be made available to ALL eligible beneficiaries. NMFA suggests careful consideration of all current DOD health care demonstration projects.

Unfortunately, these initiatives do not address the basic need for stability in military compensation and the lives of military families.

DOD is proposing several new initiatives for fiscal year 1990 to include extending the Overseas Student Travel benefit to Alaska and Hawaii and payment for the storage of cars when service members are assigned to certain areas of the Pacific. These are long overdue benefits. However, NMFA believes the stability factor must be addressed first.

Benefits that are inaccessible, unaffordable and undependable are not benefits. Pay rates below inflation and inadequate housing allowances are not competitive compensation. Newspaper headlines threatening a reduction in the number of dependents overseas immediately translate into more family separations. Military families are familiar with family separations. They understand that the defense of the country always come first. They understand mission related separations. They do not understand arbitrary budget decisions that will forcibly separate them.

Military family members are aware of the budget deficit. They are Americans, they are voters, they are taxpayers. They are volunteers who are willing to serve their country. But above all, they are people. They must have faith that those who make the decisions affecting their lives do care about them as people and do not view them just as pawns with which to balance the budget.

UNWRITTEN CONTRACT

Senator INOUE. Thank you very much, Mrs. Hickey. Do you consider the programs, the so-called quality of life programs and benefits that you have just cited, as part of an unwritten contract between those in the services and the Government of the United States?

Mrs. HICKEY. Mr. Chairman, I would go further than saying that it is an unwritten contract. In most recruiting posters you see, and I see, many of these programs are mentioned. When a young man or woman goes to the recruiting center he is told that these will be part of his life, so I then perhaps respectfully suggest that they are part of his contract, or her contract.

Senator INOUE. Well, I can assure you that we will do our best to honor the contract that we have entered into. As you know, over the years attempts have been made to do away with commissaries and exchanges. I am certain you know how I voted, so I will try to do my best. In my opening remarks when I assumed the chair, I assured one and all that this subcommittee will be spending much more time on people issues than on hardware, so we will try to keep that up.

Mrs. HICKEY. Thank you, sir.

Senator INOUE. Can we hear from you, Sergeant?

STATEMENT OF SGT. MAJ. C.A. (MACK) McKINNEY, USMC RET., LEGISLATIVE COUNSEL, NONCOMMISSIONED OFFICERS ASSOCIATION OF THE UNITED STATES OF AMERICA

Sergeant McKINNEY. Thank you, Mr. Chairman. May I start off by congratulating the Chairman on his promotion to the Chair. It is not too shabby for a sergeant. [Laughter.]

But we have maintained an excellent relationship with this subcommittee, and we look forward to many more good years under your tutelage. If we at any time may be of assistance to you or your staff we stand ready to serve. May I request that my prepared

statement be placed in the record, and I will give a brief summation.

Senator INOUE. Without objection, so ordered.

LEGISLATIVE GOALS

Sergeant McKINNEY. Thank you, sir. Also, Mr. Chairman, if I may call your attention to my prepared statement it contains the legislative goals of the association for fiscal year 1990. Now, all of the issues addressed therein are, we well know that some must be authorized before funds may be considered to be appropriated by this distinguished subcommittee. Since we do not yet know if they will be approved in the authorization process, we have given you our views in the event they are adopted.

I also would like to commend the chairman for scheduling the top enlisted chiefs to appear here before this subcommittee. This is a first. It is something I have been trying to do probably in the last 15 years to make certain that we do listen to our top enlisted chiefs. I know I have a lot of respect for, generals and admirals, but they have not lived, in many cases, as enlisted troops.

I might bring to the chairman's attention that I am a World War II veteran and I can go back and relate to many of those hardships we used to have in those days and I have been through the Korean conflict and the Vietnam conflict. But we have a different socioeconomic climate today that our young people have grown up in, and it is not like we were back in the days of the Depression.

I often said that when I went into the Marine Corps I got two pair of shoes. That is the first two pairs of shoes I ever owned at the same time, and I used to get them every 6 months—one pair—and if they wore out we would put cardboard in them. But I was real pleased that I got two pair of shoes and, in fact, I really did not know what to do with the second pair until the drill instructor told me, which was pretty definite.

PROBLEM OF FORCE REDUCTION

But one of the things that my association is concerned about is that we continue to reduce the strengths of the armed services. I made a visit out to the west coast and recently to Charleston, SC, and during that period of time it appeared to me that we have got a problem in reducing the number of people because what we are doing, we are not throwing out people, so to speak, but we are asking them to reenlist early, as early as a year ahead of time.

Now, if they do that and they are forced to make a decision in 1 year—I say in 1 month's time, for example, or after a period of 60 days, they immediately have a difficulty in reasoning whether or not they want to stay in the service for another 3 or 4 years. They are not yet fully committed to a career in the service and many of them have left. There were tens of thousands of them that left in the 1987-88 period, when we reduced the strengths of the services.

This causes a great problem out there among the enlisted troops, and I call to your attention the fact that the enlisted people are concerned that fewer people means longer work hours for many, quick turnarounds for ship-to-shore duties in the Navy, and unit rotation for those in the Marine Corps. For the Army and the Air

Force it is longer tours of overseas duty and longer family separations.

Now, overall the reduction in strength generates obstacles to retaining the best of our current service members and in the midlevel enlisted grades.

PERSONNEL PERCEIVED AS COMMODITY

Another problem is the adverse perception that military personnel believe that they are no more than a commodity, and that every time there is a talk of budget cuts, military personnel is the first on the block. Not only are many of our former service members advising their friends or families not to enlist because of this, but so are those who are currently serving.

We believe that the administration and Congress must keep the promises made or else face the same consequence as in the 1970s. We do ask you in the essence of time, Mr. Chairman, to consider our full statement. Take a look at it.

SEPARATION PAY

We are particularly interested in authorization to give enlisted people separation pay. An enlisted person can serve 19 years, 11 months, and 29 days and be dismissed or separated, discharged from the service under honorable conditions, and not receive one penny. We think that is deplorable in this day and age, where we dismiss some of our people because in many cases, because of a reduction in force.

Now, the services will argue with you and say that is not the case. We are not really reducing people. But it seems like every time there is a strength drop, suddenly we get this influx of people going out of the services. So there must be something to the reduction in force and it is not all qualitative management.

So we believe that if you take an individual who has so many years in the military service and you say, we have no longer any use for you whatsoever, then we should provide that individual like we do with everyone else—every civilian employee of our Federal Government including national hires and quasi-Federal employees like the Postal Service, et cetera, are given some type of separation pay.

But we tell our enlisted people, you're not worth it. We are not going to pay you one penny for all the faithful service that you have spent in the service. We think that is deplorable, and certainly we would like to solicit your support in that area, Mr. Chairman.

There are many other things we have addressed and again I ask the Chairman to take a look at those and do whatever he can. We certainly appreciate it, sir.

[The statement follows:]

STATEMENT OF SGT. MAJ. C.A. (MACK) MCKINNEY, USMC RET., LEGISLATIVE COUNSEL

THE NON COMMISSIONED OFFICERS ASSOCIATION

The Non Commissioned Officers Association of the U.S.A. (NCOA) is headquartered in San Antonio, Texas, with a National Capital Office (NATCO) in Alexandria, Virginia. NATCO is staffed with six (6) noncommissioned and petty officers; four (4)

retired and two (2) veterans; with a combined record of more than 140 years of military service and nearly 50 years of representing the NCOA in governmental affairs. Two additional staff members are married to military personnel. Of the eight (8) there are two each with ties to the Army, Navy, Marine Corps and Air Force.

NCOA membership is currently in excess of 160,000. It is representative of all branches and components of the Armed Forces, including the Guard and Reserve or the Retired, with a majority serving worldwide on active duty. Most of the Association's active chapters are located on or near military installations. This close relationship with the military community is the cornerstone by which the Association builds its program of legislative initiatives.

Representatives of the NCOA have been active in the Nation's Capital with annual appearances before the House and/or Senate Armed Services and/or Appropriations Committees each year since 1972. Primarily concerned with military personnel and veterans issues, these spokesmen have appeared before and worked with the above committees and others having oversight authority or the appropriation of funds for such matters as U.S. Coast Guard personnel, veterans' affairs, housing and other military facilities, impact aid for schools, taxation, social security, civil service, unemployment compensation, and so on.

NCOA takes pride in having authored the first post-Vietnam era G.I. Bill introduced in the House (1978) and Senate (1979). It is exceptionally proud to have been recognized by the 100th Congress as a federally-chartered organization. NCOA is the only military association exclusively representing enlisted members and veterans of the Armed Forces of the United States so honored.

FOREWORD

In spite of "glasnost," the world around us has changed but little. The United States continues to be the leader of the free world. Many foreign nations rely on it to safeguard their economic interests and their national security. As a maritime nation, the United States must depend on outside sources to provide raw materials and other products for the development of its commercial interests as well as a mobile, flexible, and strong defense posture. And, too, as long as the Soviet Union moves forward in building a stronger armed force to support its foreign policy, the United States cannot sit back and ignore its position in world affairs. We, the people of the United States, cannot follow. Our role is to lead.

Our nation needs to maintain a strong Army, Navy, Marine Corps, Air Force, and Coast Guard manned by quality personnel whose numbers are determined not by fiscal constraint but by the missions assigned to the armed forces. (See enclosure [1].)

To sustain the current high-state of manpower readiness now enjoyed by the United States, military compensation must be adequate, comparable, and fair. (See enclosures [2] and [3].)

Sustainability also is dependent upon quality-of-life programs that subscribe to the good discipline and morale of personnel in all components (regular, reserve, national guard, and retired) of the armed forces. (See enclosures [4], [5], [6], [7].)

Smart people are always more important to an adequate defense than smart weapons.

ENCLOSURE 1

MILITARY MANPOWER

The battle of "how many is too much or too little" will resume in the 101st Congress while debating the military manpower issue for fiscal year 1990. Unfortunately, the argument—oftimes disguised as sound military procedure—will be centered on cost rather than need.

It's difficult for middle managers to look toward major national security objectives when our senior leaders aren't explicit about (manpower) requirements. The absence of finite objectives can jeopardize attainment of valuable institutional goals.¹

So raises the question as to why there's a hesitancy to define the required strengths of the military services to fulfill the varied missions assigned to them by the Pentagon, the Joint Chiefs of Staff, and the Congress of the United States. Some manpower specialists insist that there's more behind the move for less people than meets the public eye:

¹ AIR FORCE TIMES, "Manning Issues Get Short Shrift in Defense Reports," by John Bur-
lage, Apr. 18, 1988.

- Sustaining a greater force of manpower reduces the funds that go into programs that keep civilians employed.
- Civilian employees cost the Pentagon less money than uniformed personnel.
- Uniformed officials agree to smaller strength figures while unit numbers are kept constant so that senior officer billets are protected regardless of the size of the manned forces.
- Too many dependents require greater cost outlays in the military personnel account.

In any event, the Administration and Congress appear to be playing an old game of relying on "cannon fodder" (untrained manpower) to counter-balance any future national military emergency involving the United States or its Allies. Rather than have trained manpower (smart troops) at the ready, the Pentagon prefers to place most of its fiscal resources into producing, buying and maintaining hi-tech weapons systems that only the manufacturer's technicians have the knowledge and training to keep in operating condition.

Every war or conflict involving the United States in the past 70-plus years has proved for the most part that smart weapons do not win the important battles. Time after time it has been the foot soldier, the sailor, the marine, the airmen, and coast guardsman who win the battles in spite of the availability of hi-tech systems that may not function under combat conditions.²

All of this should be a warning to the Administration and the Congress of the United States that there must be support for military manpower strengths at near the numbers authorized in the late 1950s and early 1960s after the Korean involvement but prior to the Vietnam build-up. These numbers averaged more than 2.4 million for active duty servicemembers, a comfortable strength to meet the defense needs of our nation at that period in history (see chart below), and more than 3½ million reservists.

Today, the missions assigned to the U.S. military services are nearly as great as they were in the 1950s and early 1960s. Yet, Congress endorsed a DoD proposal to slash military personnel strengths for fiscal years 1988 and 1989 (see chart below) while increasing the missions of the services in fiscal year 1989 to include drug interdiction.

The difference in strength figures for the end of fiscal year 1961 and the beginning of 1989 are shown below:

<u>ACTIVE DUTY MILITARY PERSONNEL</u>	
<u>a/</u>	<u>b/</u>
<u>1961</u>	<u>- 1989</u>
<u>U.S. ARMY</u>	
1961 - 858,622	1961 - 821,151
1989 - 771,800	1989 - 575,100
DIF. (-) 86,822	DIF. (-) 246,051
<u>U.S. NAVY</u>	
1961 - 627,089	1961 - 176,909
1989 - 593,200	1989 - 197,200
DIF. (-) 33,889	DIF. (+) 20,291
<u>U.S. AIR FORCE</u>	
1961 - 821,151	1961 - 821,151
1989 - 575,100	1989 - 575,100
DIF. (-) 246,051	DIF. (-) 246,051

- a. Actual - DoD Selected Manpower Statistics, FY 1981, p 72
 b. Authorized - CONGRESSIONAL RECORD, Sep, 28, 1988, Conference Report on H.R. 4481, Defense Savings Act of 1988, p H 8593

The most startling fact related to these numbers is the tremendous loss in estimated unit strengths. Air Force power diminished by 400 squadrons, the Army by 6 to 8 divisions, and the Navy by some 16,000 rotational slots (alternate ship-to-shore billets.) Even with a gain of one-and-one-fourth Marine divisions, the total loss in active duty combat strength is staggering . . . transferred to the National Guard and

² "It should be noted that there are some respected and respectable modern military operations research analysts who believe that the changes in weapons and technology of the past few decades have made all military history—even that as recent as World War II—irrelevant. [but] all military history is relevant to modern combat, as long as due allowances are made for the significant (but not usually overwhelming) impact of changing weapons and technology—particularly in the fields of communications, observations, and transportation. [Col T. N. Dupuy, USA Ret; "NUMBERS, PREDICTIONS & WAR; p 5]

Reserve without any loss in combat readiness. However, this is another attempt to use smoke and mirrors so the public may believe our defense forces are as effective as ever and only the cost is reduced. But in 1961 the U.S. had nearly 2.4 million people in the Ready Reserve and about 1.2 million in the Standby Reserve.³ This compares to 1.6 million Ready Reserves and 37,250 Standby Reserves, as of March 31, 1988, for a total of 1.7 million.⁴

Mathematically speaking, there's no way the active forces can lose nearly 347,000 positions from one peacetime period to another and have that loss transferred to the reserve forces. Reserve units lost nearly 2 million people from June 1961 to March 1988. 775,526 were from the Ready Reserve alone.

The irony is that defense officials boast the services can accomplish their missions even with the (extreme) loss in military and civilian manpower. (In 1961 there were 1.2 million civilians employed by DoD. As of March 1988 there were less than 1.16 million.)

It's absolutely ridiculous to even suggest that the United States, a leader of non-communist nations, can adequately defend itself and exert its influence and protection on nations around the world with a total force of 2.4 million less than it had in 1961. It's more ridiculous to insist that the United States can shift a large burden of its strategic and tactical missions to a reserve force that is 2 million less than its 1961 strength.

There are hard choices for the new Administration and Congress to make for fiscal year 1990. The services cannot afford to take another loss in its manpower structure. If, for example, the enlisted senior grades are cut through forced attrition (involuntarily ordered to retire) the result is trouble, but there are greater problems that can occur when the middle and/or lower grades are also affected. It's a case of losing leadership, mid-level supervision, and the capability to train, not to mention the people who apply the hands-on work to keep the forces at the ready.

President Reagan and others have publicly decreed that the United States will never fight another war without the commitment to win; that there'll never be another Vietnam. Though that promise has been voiced, there has been no pledge that our young men will be trained adequately to avert the slaughter that an older generation suffered in Vietnam—more than 50,000 deaths.

There's only one way to alter the future for our young people whom we may call upon to physically place their lives in jeopardy for their country and country-men. Make certain there are adequate numbers of trained personnel in the armed forces to assure a continued high-state of combat readiness.

ENCLOSURE 2

READJUSTMENT PAY

Fact: Active duty nondisabled enlisted servicemembers are not entitled to readjustment (severance or separation) pay although active duty commissioned officers are authorized such pay averaging nearly \$29,000 for each separatee.

Proposal: NCOA recommends that Chapter 59, Title 10, USC, be amended by adding a new section 1175 that authorizes readjustment pay for certain active duty nondisabled enlisted personnel. (A copy of the proposed legislation is available from the NCOA National Capital Office.)

Justification: Such pay, under whatever name, has been recommended by Defense studies; governmental commissions, committees, and agencies; military departments and top military leaders; and private enterprise. (A complete list is available from the NCOA National Capital Office.)

Active duty nondisabled enlisted servicemembers are the only full-time Federal or quasi-Federal "employees," including foreign hires, not entitled to readjustment, severance, or separation pay. This inequity applies to those enlisted servicemembers with as many as 19 years, 11 months, and 29 days of honorable service. They receive not one penny from the U.S. government to assist in transitioning to a civilian environment.

Reserve enlisted personnel of the Armed Forces called to active duty but denied further active service following a prescribed period are entitled to readjustment pay.

For further information, see Appendix A attached.

³ Dod Selected Manpower Statistics, FY 1981, p. 185.

⁴ Defense 88 Almanac, Sep/Oct, pp 32 and 33.

APPENDIX A TO ENCLOSURE 2

READJUSTMENT PAY

The Officers Personnel Act of 1947 provided severance pay to commissioned officers who were mediocre on a par with more industrious, more capable officers.

The Act's legislative intent was to provide the military services with: "The type of incentive, promotional and elimination programs the services will require for permanent and temporary . . . officers." Further to effect a system whereby all officers who are unqualified and incompetent are forced out. The unqualified, incompetent, and "patently unfit" officers would, under the Act, be entitled to severance payments up to and, in some cases in excess of \$15,000.00.

"Severance" pay for officers has now been changed to "separation" pay and can amount to a maximum of \$30,000.00, or double the earlier sum. For 1987 (the latest figure available to NCOA) it was estimated that 1,074 regular officers would receive an average payment of \$28,971.00 and 626 reserve officers would receive an average of \$27,781.00 for a total cost of \$48,506,000.00.

Some officers, commissioned subsequent to receipt of more than \$100,000.00 in Federal educational support at one of the military academies, can be declared "mediocre" and be entitled to separation pay.

Yet, there is no like-entitlement for enlisted personnel of the regular (active duty) forces. They may be involuntarily separated from the armed services and receive not one red cent to assist them in readjusting to a civilian (and sometime a rather hostile) environment. This is true regardless of their time in service, up to 19 years, 11 months, and 29 days to be exact.

The 1947 Act, and its successor, the Defense Officers Personnel Management Act (DOPMA) of 1980 (Public Law 96-513) failed to include regular enlisted personnel of the U.S. Armed Forces, though for reasons unknown to NCOA the Act of July 9, 1956 (Public Law 84-676) and DOPMA offered some form of separation pay to reserve enlisted personnel with at least five (5) years of continuous active duty under the same provisions applicable to reserve commissioned officers. (Few, if any, reserve enlisted personnel ever qualified in practice.)

Separation or severance payments to regular nondisabled enlisted personnel is not a new idea. It was awarded to enlisted servicemembers in the 1800s and mid-1900s. The Act of May 14, 1800 (2 Stat. 85) for example, empowered the President to discharge noncommissioned officers and privates (enlisted personnel) with three (3) months' additional pay. Later, the Act of Dec. 24, 1811 (2 Stat. 669) awarded a "bounty" of three (3) months' pay and 160 acres of public land to all former enlisted personnel who had "faithfully performed their duty whilst in service."

At other times, separation (or severance) pay was paid without regard to the voluntary or involuntary nature of separation on which it was predicated. Following World War II and the Korean conflict, all military personnel discharged or separated under honorable conditions received up to three (3) months "mustering-out pay."

Currently the active duty nondisabled enlisted servicemember is the only full-time governmental or quasi-governmental "employee" NOT ENTITLED to some sort of severance, separation, or readjustment pay from the Federal Government upon separation from his or her employment prior to attaining retirement eligibility. Though governmental employees are entitled to unemployment insurance compensation, Congress has agreed they are entitled to severance pay to compensate for loss of job, seniority, and benefits, and disruption of their lives.

The U.S. government has applied such theory in its relationship with foreign nationals hired to work with the Defense and State Departments. One group of Japanese nationals under contract by the Pentagon was awarded an average of \$200,000.00 each when their contract was voided.

Others also have benefited as a result of congressional interest in equity for employees separated from their livelihoods. About 10 years ago a special congressional action awarded some private-sector loggers the equivalent of \$50,000.00 in government subsidies when their logging activities were terminated by the Federal Government.

In comparison, 437 Navy petty officers and 249 Marine noncommissioned officers in enlisted pay grades E-6 thru E-9 were involuntarily separated, denied reenlistment or discharged during fiscal years 1976 and 1977. Many were Vietnam-era veterans. They had served 6-to-19 years of active duty. The U.S. government was so grateful for their services that they were rewarded nothing to assist in readjusting to civilian life.

Or take the case of the U.S. Army. In a 4 year period (1974-1978) following the Vietnam conflict more than 20,000 soldiers were separated through that service's

"qualitative management program" (QMP), also the Army's name for a reduction-in-force (RIF). Some were separated and denied reenlistment even though they served valiantly in Vietnam. Their reward from an appreciative government was ZERO DOLLARS.

The denial of readjustment (separation or severance) pay to certain enlisted military personnel is blatantly unjust. As U.S. Representative Henry B. Gonzalez, M.C. (Texas) said: "... We are treating enlisted personnel unjustly. ... the Department of Defense supports severance pay for its many civilian employees as well as its indirect hire and associated foreign national employees plus its uniformed commissioned officers, but denies the pay to those enlisted."

ENCLOSURE 3

MILITARY COMPENSATION

Fact: Military compensation continues to fall behind comparable private sector pay. Currently, military pay scales—including the 4.1 percent increase for January 1, 1989—reflect the following problems:

- Pay levels are below that which caused tens of thousands of military personnel to quit the armed services in the late 1970's;
- BAQ & VHA are some 6½ percent below their intended absorption of 85 percent of a member's housing costs;
- NCO pay continues to be compressed with no relief since fiscal year 1982;
- PCS reimbursements remain totally inadequate;
- Certain personnel are forced to forego partial reenlistment bonuses due to forced early retention decisions.

Proposal:

- Increase basic pay, BAS, BAQ, and VHA to more closely match that of comparable private sector pay and congressional intent.
- Address the NCO pay compression issue by programming greater increases in pay and allowances for NCO grades (E-4 thru E-9).
- Increase PCS authorizations and fundings so as to be more equitable in reimbursing military personnel for moving under government orders and, stop considering pcs reimbursements as compensation.
- Provide authority and funds to military services to pay bonus money to enlisted personnel forced to make early decisions concerning reenlistment.

Justification:

- Military pay is 10.4 percent behind comparable private sector pay (using the Employment Cost Index—ECI).
- BAQ and VHA have failed to keep pace with housing costs. For example, these costs went up 8.5 percent in 1987 leaving military personnel holding the bag for 22% of their housing. Even with a 7 percent increase in BAQ funds and 3.3 percent hike in VHA appropriations, servicemembers will continue to pay 6½ percent more for housing than intended by Congress.
- The ratio of pay for a senior NCO to a recruit servicemember has dropped from a high of more than 4:1 in 1940 to 3:1 in 1988. Additionally, Public Law 99-348, which changed the military retirement system "to encourage longer service," failed to address pay scales for mid-level NCOs that do not increase for time-in-service beyond 18 years.
- PCS reimbursements continue to be considered as compensation when, in fact, it is dollars returned to a servicemember for spending his or her own money when moving under government orders. Reimbursements authorized are about \$1.00 (more or less) for each \$3.00 to \$4.00 paid out by the servicemember. Civilian employees of the Federal Government receive much higher reimbursements.
- To effect reductions in end strengths, military services use an "early out or early reenlistment program" that forces enlisted personnel to separate or reenlist as early as 1 year prior to their existing contract's expiration date. Those who reenlist must return any bonus money received as a result of the previous contract for time not actually served.
- Military personnel assigned overseas have no control over the dollar's reevaluation in the foreign nation to which they are assigned for duty. Those living on the civilian economy are at the mercy of the local economy. The military needs to do all it can to keep the purchasing power of the dollar at its U.S. value for all military personnel overseas.

ENCLOSURE 4

FORMER SPOUSES PROTECTION ACT (FSPA)

Fact:

- Civil Courts and the Military Services are not complying with certain provisions in Public Law 97-252 relating to the rights of servicemembers, thereby, negating the requirement for certification/jurisdiction and placing the burden of the court's validity on the servicemember instead of the court itself.
- Civil courts are misinterpreting the law.

Proposal:

- Direct the Secretary of Defense, the Service Secretaries and the Civil Courts (as defined in FSPA) in the strongest language, that compliance with the applicable provisions of Section 1408, Title 10, U.S.C. is a must before any payments will be made by military finance centers upon receipt of a court order dividing a servicemember's retired pay.
- Direct civil courts considering the division of military retired pay as provided in Public Law 97-252 that they must comply with the provisions of that law.

Justification:

- The FSPA requires that a court order certify that the rights of the active duty member under the Soldiers' and Sailors' Relief Act of 1940 were observed or, in the case of the retired member, the court issuing the order has "competent jurisdiction." However, the Military Services have been directed to honor the court order as long as it appears valid on its face. This, then, leaves the matter to be resolved by the member or retired member who may need to initiate legal action to prove what the Federal law directs the issuing court what it must do in the first place. Filing a counter-claim in a court issuing the order, that it did not honor the right of jurisdiction, can possibly constitute latent jurisdiction and allow the court to subsequently certify that it has complied with the Federal statute.

ENCLOSURE 5

MILITARY HEALTH CARE

Facts:

- The purpose of the military health care system is to create and maintain high morale in the uniformed services by providing an improved and uniform program for eligible beneficiaries (10 U.S.C. Ch 55). Medical care for nonactive duty beneficiaries is a "high moral obligation" based on promises made to servicemembers as inducements to enlist, reenlist and stay for careers. (1974 House Armed Services Committee Report on Military Health Care.)
- Military Treatment Facilities (MTFs) are experiencing problems in providing health care for mostly nonactive duty beneficiaries. Much of the difficulty rests with the military and its failure to prioritize medical programs, adequately man MTFs, and modernize and equip its facilities for more effective care.
- There's a probability that a recommendation to apply a co-payment scheme, user fee and/or increase CHAMPUS costs for beneficiaries will be made to or in Congress.
- CHAMPUS continues to be an overburdened, costly, confusing, and bureaucratic program that fails to appeal to many nonactive beneficiaries and the medical community.

Proposals:

- Provide adequate funds to the military to recruit, retain, and hire adequate numbers of health professionals and technicians and administrative personnel to man and to modernize and equip MTFs.
- Prohibit any co-payment scheme, tax, or health care user fee in MTFs and forbid any increase in CHAMPUS costs for beneficiaries.
- Continue to fund and authorize commanders of military catchment areas to use any combination of available health services, military and civilian, to provide beneficiary care.
- Decrease CHAMPUS catastrophic cap for military retirees and their dependents from \$10,000 to \$3,000.
- Study the feasibility of authorizing the delivery of health care at civilian-operated treatment facilities in order to phase out the CHAMPUS program as it currently exists.

- Authorize the use of CHAMPUS by dependents, residing with their active duty sponsors who are assigned to permanent duty and domiciled outside a military catchment area, at less cost than required under current CHAMPUS provisions.
- Continue authorizing the use of and funding for the Uniformed Services Treatment Facilities (USTFs)
- Contract with Veterans Administration Hospitals and health clinics to accept retired personnel for no-cost health care.
- Allow nonactive duty beneficiaries over 65 years of age to use CHAMPUS for care not available under Medicare if they reside outside the military catchment area or cannot receive the required care at MTFs.

Justification:

- Military health care has deteriorated over the years for many reasons, primarily due to soaring costs, inadequate personnel to man MTFs, and the slow reaction by the military to modernize and equip its facilities with the latest in hi-tech health care systems and equipment.
- Other reasons are covered in "Facts" above.

ENCLOSURE 6

MISCELLANEOUS

FACT. 1. Temporary Duty/Per Diem Allowances for Enlisted Personnel. In 1980 Congress authorized the payment of these allowances to enlisted personnel in the same manner as afforded officer personnel. The appropriating committees failed to fund the program and in the DoD Appropriations Act, 1985 (Public Law 98-473, section 101(n)), added language that offset equitable treatment.

PROPOSAL. Repeal subsection 404(g) of Title 37, U.S.C. and direct the funding for the remaining applicable provisions of section 404 pertaining to temporary duty did for enlisted personnel as intended in Public Law 96-513, Title IV, Part B, Section 411.

JUSTIFICATION. Public Law 96-513 provided that, for the first time in history, military enlisted personnel would be authorized equal consideration with commissioned officers in determining diem reimbursements for performing temporary duty away from their permanent stations. Previously, officers received greater reimbursements; however, new rates for enlisted subsistence allowances (BAS) for enlisted members continued to rise until a reversal occurred. DoD complained that the new system is unfair so Congress refused to fund the authorization. NCOA believes the program of per diem should be equitable to all military personnel, regardless of grade.

FACT: Temporary Lodging Expenses (TLE). Authorized by Congress to include all military grades but not yet fully funded.

PROPOSAL: Direct full funding for Temporary Lodging Expenses (TLE) for all qualified military personnel. (Ref: 37 U.S.C. 404a).

JUSTIFICATION: Temporary Lodging Expenses (TLE) were authorized by Congress to help in easing out-of-pocket expenses for military personnel executing permanent changes of station orders issued by the U.S. military. Originally restricted to pay grades E-4 and below, the program was subsequently opened to all grades but no additional funds were appropriated to handle the extra beneficiaries.

FACT: Morale, Welfare, and Recreation (MWR) facilities and Programs. Congress has reduced fundings resulting in the closing or reduction in operating hours of these facilities and the scope of programs available to maintain the good order and high morale of military personnel, especially single junior enlisted members.

PROPOSAL: Provide adequate funds for Morale, Welfare, and Recreational (MWR) facilities and programs necessary for the good order, discipline, and morale of military personnel, particularly single and junior enlisted servicemembers. (Ref: Defense Appropriations Act, fiscal year 1989, SEC. 8111).

JUSTIFICATION: Rather large cuts in past years' fundings for MWR facilities and programs have severely impacted on their management, operation, and availability. Many are at risk, especially those providing younger servicemembers with healthy recreational activities, enhancing morale, and keeping them onbase to lessen the chance of involvement in questionable or suspect ventures. Further, high prices and crowded conditions in many civilian-operated recreational facilities located in large metropolitan areas near military installations preclude their use by junior enlisted personnel, in particular, and retired military members whose military retired pay is below the poverty level.

(NOTE: More than half, 55.97%, of members on retired rolls, earn less than \$11,000 annually in military retired pay, based on DoD statistical data as of Sep. 30, 1987.)

FACT: Survivor Benefit Plan (SBP). Currently not a fully attractive package. Personnel are all but involuntarily enrolled in program upon retirement. Also a costly plan for members who live average life span; they pay in far greater sums than surviving spouses realize in annuities.

PROPOSAL: Amend the Survivor Benefit Plan (SBP) so that it is more attractive to servicemembers and provide a plan that compares to that authorized for paramilitary employees of the Federal Government. One recommendation is to provide an across-the-board annuity of 50% of the base amount of the member's covered retired pay regardless of the age of the surviving spouse. (Ref: 10 U.S.C. 1450).

JUSTIFICATION: Survivor Benefit Plan. See Fact above.

FACT: Tuition Aid. Reduced funds have curtailed the use of program to provide greater educational opportunities for career enlisted personnel.

PROPOSAL: Fund the Tuition Aid program so that it again covers 90% of the students' cost. (Ref: 10 U.S.C. 2007(a)(1)).

JUSTIFICATION: Tuition Aid requires full funding for up to 90 percent of allowable costs. Promotions are linked to education; senior NCOs are "encouraged" to obtain Associate degrees. Advancement opportunities are limited if civilian education ignored. Many members do not have G.I. Bill eligibility, must use tuition assistance.

FACT: Employment Preference. Spouses may lose reemployment preferences upon members' retirement and relocation.

PROPOSAL: Authorize spouses to retain reemployment preference upon retirement and relocation of servicemember, limited to one-year from the date of the members' retirement. (Ref: The Military Family Act of 1985; Public Law 99-145, Title VII, Sec. 806).

JUSTIFICATION: Reemployment preference has been extended to spouses of members being reassigned as result of permanent changes of station (PCS) orders. Such preference should be extended to spouses of members retiring and relocating with a one-year time limitation on one-time only basis.

FACT: Travel and Transportation. No transportation is provided for the remains of spouses or surviving spouses to place of residence when such persons die while undergoing hospitalization in a Military Treatment Facility (MTF).

PROPOSAL: Authorize the transportation of the remains of spouses or surviving spouses to places of residence when their demise occurs while undergoing hospitalization at a Military Treatment Facility. (Ref: 10 U.S.C. 1490)

JUSTIFICATION: Transportation of the remains of retired members dying while hospitalized in an MTF has been authorized. It would be appropriate as well as humane to grant an identical authority to spouses or surviving spouses of retired members. The cost apparently would be insignificant.

FACT: Military Retired Pay—Cost of Living Adjustments. COLAs for military retired pay are not receiving the attention that should be given to this important issue by the Armed Services Committees

PROPOSAL: The Armed Services Committees are encouraged to play a greater role in determining COLAs to military retired pay and not acquiesce to those committees having oversight of Federal employees' issues. (Ref: 10 U.S.C. 1401a) (Also see Item 11 under JUSTIFICATION below)

JUSTIFICATION: Cost-of-living adjustments (COLAs) to military retired pay are determined by law (Title 10, U.S.C.), however, whether the COLA is to be effective or not seems to be at the discretion of the House Post Office and Civil Service Committee and its sister Senate Committee. Although military pay has been "married" to Federal pay for some years, the two systems have slowly gone their separate ways. The Armed Services Committee needs to regain its full authority over this important issue with the military's retired members.

FACT: Retired Servicemen's Family Protection (RSFPP). Many members are locked-in the plan and continue to have reductions made from their retired pay although they no longer have an eligible living beneficiary. Participants are not authorized to convert from RSFPP to SBP.

PROPOSAL: Amend current statutes that will authorize all members participating in the RSFPP to withdraw from participation whenever their beneficiary or beneficiaries predecease the member or are no longer eligible for the annuity under the plan and to convert to the Survivor Benefit Plan upon request. (Ref: 10 U.S.C. 1436(b)).

JUSTIFICATION: The RSFPP locked many participants into the plan long before the advent of the Survivor Benefit Plan (SBP). The latter, like the RSFPP, original-

ly possessed a "once in-always in" provision but subsequently was amended to authorize withdrawal from participation if the member's spouse predeceases him or her or the member is divorced from the spouse. No such language exists in the RSFPP for those members locked in the plan by virtue of a choice made prior to the current SBP. Further, when SBP was created a small number of military retirees found it more financially beneficial to remain enrolled in RSFPP. Recognizing similar anomalies Congress, in creating the Improved Pension Program for veterans, allowed veterans to retain enrollment in the old veterans' pension program until it was to their financial advantage to change. Most veterans have now converted, however, a few still retain the old pension. In the case of RSFPP participants, conversion to the more advantageous SBP program was allowed only twice. Notwithstanding the predictable advantages of subsequent conversion as the SBP program improved and as RSFPP declined. Therefore NCOA believes it would be appropriate for Congress to allow conversion upon request to retired servicemembers. The cost would be negligible.

FACT: Military Retirement Fund. The fiscal year 1989 Defense Authorization Act authorized the use of military retirement funds to pay annuities to retired judges of the Military Court of Appeals.

PROPOSAL: Repeal the statute that authorizes member-judges of the Court of Military Appeals to have access to the military retirement fund. (Ref: fiscal year 1989 National Defense Authorization Act, Section 722).

JUSTIFICATION: The judges affected by the recent action of Congress sets a precedent that can have adverse effects on the military retirement fund. "The judges are not military but civilian Federal workers." They contribute nothing to the military retirement fund and, therefore, should not be authorized access to that fund for retired compensation.

FACT: The fiscal year 1990 Federal budget may request no cost-of-living adjustment (COLA) to military retired pay and survivor benefits for the year beginning Dec. 1, 1989, and a one (1) percent reduction in annual COLAs thereafter.

PROPOSAL: To revoke any proposal to cancel the 1990 COLA to military retired pay and survivor benefits and the one (1) percent reduction in subsequent COLAs in 1991 and thereafter unless social security COLAs are given identical treatment.

JUSTIFICATION: The statute determining the COLA to military retired pay has been amended any number of times since the early 1960s. Each has reduced the amount of the COLA to the recipient. For survivor benefits, the law reads that reductions in a participating member's retired pay produces a survivor annuity that will be increased each time military retired pay is increased under 10 U.S.C. 1401a. Section 1401a states that the "Secretary (of Defense) shall increase the retired pay of each member and former member" ... "effective on December 1 of each year." There is nothing in the statute that states that the COLA may be denied.

ENCLOSURE 7

GUARD AND RESERVE

FACTS 1. There is an absence of affordable health care insurance for members of the guard and reserve.

2. The Coast Guard Reserve is not receiving the budgetary support it deserves to carry-out its assigned mission.

3. There is a need to amend the current system whereby members of the reserve component can earn additional retirement points for performing non-regular service.

4. Commissioned officers with reserve service on or before May 31, 1958, may compute retired pay using that service as creditable time for retirement purposes. Enlisted personnel cannot.

PROPOSALS 1. Authorize DoD to report on the feasibility of including guard and reserve personnel in the non-subsidized group health insurance program now available to former military personnel and certain dependents (Ref: 32 CFR Part 104; fiscal year 1985 DoD Authorization Act)

2. Direct the Secretary of Defense to join with the Secretary of Transportation in presenting and supporting a more realistic budget for the Coast Guard Reserve.

3. Amend the current reserve component point system so that a member of that component may earn a greater number of points that can be computed to determine the amount of the member's retired pay. The proposed system recommended by the 6th Quadrennial Review of Military Compensation (6th QRMC) appears to be a fair and equitable solution. (Ref: 10 U.S.C. CH 67 and 6th QRMC, Vol. 1B, National Guard and Reserve Retirement, July 1988.)

4. Authorize retired enlisted personnel with reserve service on or before May 31, 1958, to recompute their retired pay to reflect such service as now afforded commissioned officers. (Ref: 10 U.S.C. 1401 and 1405.)

JUSTIFICATIONS 1. The absence of proper health care has an adverse effect on readiness, recruiting, and retention of guard and reserve personnel. Non-availability of affordable health insurance plus the possibility of catastrophic illness affects the servicemember's deployability. Lack of medical insurance coverage has resulted in general neglect of vital health care for these servicemembers and their families.

2. Previous years have seen a real loss of funds for the Coast Guard Reserve. The losses have cut into the muscle and bone of the Coast Guard's ability to prepare for critical national defense efforts. Continued nonsupport of the Coast Guard reserve will result in its inability to protect the nation's ports and coastal waters in time of military threat.

3. Many members of the reserve component are dedicated servicemembers who offer their additional time to provide improvements in unit operations, administration, and training, their own occupational specialty or military professionalism, or in relationships with the local civilian community. They are now, however, limited to a maximum of 60 retirement points per annum which may be attained through required periods of drill and inactive duty training periods. Dedicated members who volunteer for extra duties directly related to the reserve unit's mission should be able to accumulate at least 75 credible retirement points for each year of non-regular service.

4. There appears to be no reasonable cause surrounding the statute that permits commissioned and warrant officers to credit certain periods of reserve time when computing their retired while denying the entitlement to career enlisted personnel. It is past the time for Congress to rectify the situation and authorize enlisted personnel identical privileges.

Senator INOUE. Mr. McKinney, I have read your statement. I can assure you that those concerns of yours are concerns of mine, such as the recognition of time less than that required by law.

TRAINING

I think you have got a good point there. However, there are certain statements that puzzle me and concern me. For example, in your prepared statements you said, and I quote, "The administration and Congress appear to be playing an old game of relying on cannon fodder for any future military emergency."

The four senior enlisted men testified as to their soldiers and sailors and marines being the best trained in the world. And do you believe that our men are not sufficiently trained?

Sergeant MCKINNEY. I do in some certain cases, yes, sir. If we take an individual and we put him in the service for 2 years, I do not believe we train that individual properly in today's climate in the military services.

We are even high tech in the infantry today. You and I well know that we had a machine gun and a rifle was about the extent of what we were armed with as grunts. But today you have got the interrelationship of communications and logistics and et cetera within—even in your infantry. That does not afford—we cannot afford to train the individuals for 2 years.

That is one of the reasons that I oppose, and my association opposes, the National Service Program. We are talking about 2 years' service, and you really cannot train an individual in 2 years to do the things that are properly needed when that individual goes into a combat situation. And we are, one of these days—I hopefully will not see a war of a major size that we had in World War II, for example, or even in the Korean conflict.

But I think we need to have our people prepared, and I think General Gray said very well last year when he was talking, about the Congress had cut down the number of training days that the individual could train, on the recruit training down from 12 weeks to 10, and I always in my years in the Marine Corps, that 12 weeks was necessary to train that individual.

MAINTAINING LARGE FORCES

Senator INOUE. The other statement that concerned me was that you suggested that it would be impossible for the United States to defend itself and exert its influence in the world if we did not maintain our military force equivalent to that which we had in 1961 which, incidentally, was the Vietnam period.

Do you think at this time we should maintain that large a force?

Sergeant MCKINNEY. If we continue the mission, sir, that is one of the things that I think I said in my statement. If we continue to place upon the services the missions that they have, we need those people. And I am happy to hear that the chairman is going out and visiting the enlisted people.

And a good example of that is Castle Air Force Base, which is out here in California. That is a B-52 base, and they are on alert 24 hours a day.

But the problem is they do not have enough people in there to do the job. They have one staff sergeant to every two planes when they need one for every plane, and they had some young airmen and we called them—well, airmen first class, I guess, the E-5's, who are not fully trained yet to take over the position of that staff sergeant who is the crew chief on the plane.

So, we do have, as long as we continue to have those missions. We have as many missions today as far as I can tell, Mr. Chairman, as we had in 1961.

Remember, the balloon did not go up until 1965, but in 1961 we had what we thought was enough people to take care of the tasks and the missions on hand. And that is the reason we think that there is a necessity in having somewhere around 2.2 million people in the service today, to do the job and the missions that we give them.

WALTER REED PARKING SPACE

Senator INOUE. Mrs. Hickey, this committee will be spending much more time than the predecessor committees on the improvement of medical and health care. We are well aware that it is a multifaceted problem, for example, at Walter Reed here. You may have the best doctors, the best nurses, full compliment, but if you do not have parking space, you are not able to meet your scheduled appointment and everything goes haywire.

Walter Reed, for example, is requesting appropriations to build a multideck 3,000-space parking area. All the services are now asking for special bonus payments to retain certain specialties such as orthopedic surgeons, optometrists, and that type—ophthalmologists, not optometrists.

Then they are also asking for new hospitals or improvement in such. If you had to provide us with a priority list, what five items would you consider to be of the highest priority?

Mrs. HICKEY. In medical care?

Senator INOUE. Yes.

ACCESSIBILITY HIGH PRIORITY

Mrs. HICKEY. I think the first one has to be accessibility. Now, that is given the fact that we are going to assume we have the quality, which we do believe we do have. I mean, the quality must obviously remain the same.

And, unfortunately, with inaccessibility come a great many of the other things. You cannot access your medical treatment if there are no doctors there, or nurses there, or beds open. It becomes difficult to access care, if you cannot find a parking spot in the garage as well.

As far as new construction is concerned, we are perhaps more interested in the one hospital overseas that we know that there is a request for, and that is the one sitting in Naples now. We are waiting to hear headlines one of these days that that very active volcano becomes extremely active with patients in the beds.

I think it is unreasonable to expect that we can take care of all eligible beneficiaries in the direct care system. NMFA has always said that given the current situation that would be impossible. We have to recognize that and go forward. But CHAMPUS—the CHAMPUS Program is not only expensive to the Government, it is extremely expensive to the individual.

That is why NMFA has been working very carefully with the demonstration projects that are going on, the CHAMPUS reform initiative, the project down in the—the PPO project down in Florida and Georgia, and the base catchment area projects which are underway.

Hopefully, out of these projects will come some sort of system that military families can rely on now and in the future.

CHAMPUS

Senator INOUE. What do you think about the CHAMPUS requirement of \$100 deductible.

Mrs. HICKEY. I am not so concerned about that \$100 deductible or the \$50 deductible per person. What I am concerned about is the fact that our beneficiaries cannot find doctors who will accept CHAMPUS assignment. Our young E-4 going out there thinks he is going to pay 20 percent of a \$100 bill and he is ending up paying \$30 and \$40 of it. And to him, that is a lot of money.

So, I am more concerned—the \$100 and the \$50 is something that he has known all along. He knows he has got to come up with that. That is a flat amount. He knows how much that is going to be. But what he does not know is how much his portion of the outpatient cost is going to be when he has to take his family outside because he cannot get them in a military treatment facility.

Now, if he were guaranteed that that cost would only be \$10, for instance, in the CHAMPUS primary, the CRI demonstration in

California and Hawaii, that might make it easier for him to adjust. Whatever he has to pay, it is a reduction in compensation.

That E-4 was promised free medical care for himself and his family for as long as he stayed in the service and if he stayed to retirement, for as long as he lived afterwards.

PRESCHOOL DAY-CARE CENTERS

Senator INOUE. Do you believe that if we had more preschool day-care centers, it would help in the recruitment of personnel?

Mrs. HICKEY. Considering the fact that right now, particularly in the enlisted ranks our wives, working wives not in uniform are subsidizing their husband's career and they are not able to work if they do not have child care, recruiting, no, retention, yes.

FAMILY CARE

Senator INOUE. Are you in agreement with the four senior enlisted men that our programs on family care are moving along well?

Mrs. HICKEY. I think I would probably have to come down on the side of Chief Master Sergeant Binnicker. I think our families are beginning to question their future.

We have certainly moved along in the last 10 years into a direction of quality of life for our family members and for our single members. I think 2 years ago they had to take a cut in take-home pay. That is awfully hard to explain to somebody when you are trying to tell them they had a 2-percent raise.

We had people who had 60 percent of the Air Force, I believe, who had their VHA reduced this year. We have people who are not able today to buy what they could yesterday, and it is very hard to tell that family that they are better off in 1989 than they were in 1988.

Senator INOUE. That is one of the reasons I am spending more time with people like you. Otherwise, this committee would be doing the same thing and spending more time on the Stealth bomber, the B-1, and 1A1 tanks, all the big items. They are very expensive.

And we will have to make a decision. And I can assure you that we will not let your husband down.

Mrs. HICKEY. Thank you, Senator.

Senator INOUE. Mrs. Hickey, I thank you very much, and, Sergeant Major, I thank you very much. You have been very helpful, and I can assure you that we have read your statement, and I will go over them again. And we will do our best to make certain that our military remains the best on this planet.

Sergeant MCKINNEY. Thank you, Mr. Chairman. We appreciate it.

SUBMITTED QUESTIONS

[The following questions were not asked at the hearing, but were submitted to the services for response for the record:]

QUESTIONS FOR THE ARMY SUBMITTED BY SENATOR INOUE

IMPROVING THE PROVISION OF MEDICAL CARE

Question. For many years, I have closely followed the performance and effectiveness of the medical facilities and services provided by the Department of Defense. In spite of significant increases in expenditures, I remain concerned about access to health care and the cost of CHAMPUS to the service member for dependents. Gentlemen, from your perspective, where should we focus our efforts in improving the provision of medical care to service members and their families—in DOD medical treatment facilities or into reducing co-payment costs of CHAMPUS?

Answer. Access to quality medical care is perceived as the major quality of life issue for soldiers and their families. Soldiers want to be assured that their family members will have medical care available, regardless of duty assignment and want to know what will be available for them and their family members at retirement. The Army's goal is to provide cost effective health care to its entitled beneficiaries. The Army recognizes this responsibility and is committed to providing care inhouse within the direct care system or by arranging for care through CHAMPUS. Emphasis should be placed on improving care within DoD medical treatment facilities. Health care provided within the direct care system at Army medical treatment facilities (MTFs) is generally cheaper than care procured through the civilian market, and beneficiaries feel more secure within a system with which they are familiar. When this is not possible we should insure that beneficiaries are provided care that does not require extraordinary out of pocket expenses to the service member. Because military life requires many moves to unfamiliar communities and because most soldiers live near or on an installation it would be most convenient and economical to expand services and improve access to the direct care system. In addition, relying too much on CHAMPUS could erode the inhouse peacetime health care system and directly affect our ability to sustain Graduate Medical Education programs, upon which we are absolutely dependent to meet wartime readiness requirements. The Army is currently budgeting, correctly in my opinion, for health care initiatives that focus on: Improving access to the direct care system; viewing CHAMPUS and the direct care system as a partnership; and, by making full utilization of staff and facilities to provide care within Army MTFs when it is demonstrated to be the most cost effective method to provide health care. I do not believe that improving services within DoD MTFs and reducing co-payment costs of CHAMPUS are mutually exclusive. Recent actions indicate that these concepts should be complementary. Through the use of the Partnership Program, using CHAMPUS funding, we are contracting to staff Army MTFs with physicians and other clinical support when they are not available within existing staff inventory, to continue or improve services inhouse. We currently have over one hundred agreements established. The Alternate Use Program, another CHAMPUS funded initiative, permits the Army to add a service inhouse if it can be clearly demonstrated to be a cost savings to CHAMPUS. We have ten initiatives approved. Beginning in FY90 at Health Services Command a program called CHAMPUS Management will start. This program will provide staffing for large MEDDACs with high dollar CHAMPUS volume to coordinate and contract for cost effective CHAMPUS alternatives for beneficiaries. Through improved management of CHAMPUS and seeking CHAMPUS alternatives the CHAMPUS deductible and co-payment structure might be reduced along with the total CHAMPUS bill. Overall however, in my opinion the Army and the soldier will benefit most over the long run by expanding and improving our DoD medical treatment facilities.

MEDICAL COMPLAINTS

Question. What are the most frequent complaints or problems that service members or their families raise concerning care at DOD medical facilities?

Answer. The most frequent complaints or problems revolve around access to the health care system. The Army Medical Department is obligated to provide first priority care to active duty members. All other eligible beneficiaries are treated as space and capabilities permit. Unfortunately, limited resources translate into long waiting times for appointments and frequent referrals for other than active duty personnel to seek care in the civilian sector under CHAMPUS or MEDICARE as appropriate. Soldiers, their families, and retirees and their families expect comprehensive "free" medical care. The Army Medical Department cannot provide that level of care to all eligible beneficiaries within current resource constraints.

EQUIPMENT OR PEOPLE

Question. One of the areas we may be forced to reduce because of budgetary shortfalls may be continued modernization of equipment.

Could each of you comment, from your perspective, if your services have the right equipment in the right amounts to perform your mission adequately?

Answer. Budgetary shortfalls are a reality with which the Army must deal, even in the face of the present and expected global threats to our security interests. Modernization of Army equipment must continue if we are to maintain credible deterrent and warfighting capabilities. Indeed, force modernization must continue to be a top priority.

Due, in large part, to congressional support, the Army is continuing to modernize. However, force modernization is a journey and not a destination. Presently 59 battalions have been modernized with the Abrams tank and 33 battalions have Bradley Fighting Vehicles. These, and many other modernized systems, contribute greatly to our ability to accomplish assigned missions. These systems are also only evolutions of equipment designed to meet the evolving threat.

As we modernize equipment, we also modernize force structure. We have progressed from H to J to L series tables of organization and equipment (TOEs). Approximately 20 percent of our units have been modernized under J series and approximately 30 percent are L series.

Congressional support is needed to continue the process of modernization. While the right equipment in the right amounts is an important determinant of our capability to accomplish assigned missions, the effectiveness of equipment is also a significant determinant. Modernization is essential in achieving this effectiveness, especially in the context of possible reductions in equipment quantities and an evolving threat.

Question. Do you think "People Programs"—pay and benefits—should have a higher priority than new weapons acquisition?

Answer. The Army's budget priorities have essentially remained the same since we've entered a period of constrained resources. Those priorities were to protect the quality of the force, to ensure that near term readiness did not suffer appreciably, that we would retain as much force structure as we could in view of the Army's current size versus mission requirements, and we would slow the pace of modernization. We have in fact, protected the quality of the force by reducing weapons acquisition.

Question. If force structure were reduced, it might be possible to do both—buy and maintain new equipment and take better care of people. Do you think the military could fulfill their mission with fewer people?

Answer. No. Today our Army is at the smallest level since 1950. Given worldwide requirements the Army force structure is at about the right mix—Heavy, Light, Special Operations—but the numbers are inadequate considering our national strategy—first to deter war, but fight if necessary and win.

ADVERTISING

Question. Recruiting advertising is done both by the individual services and the Joint Recruiting and Advertising Program. For 1990, the active services have requested \$124,399,000 for their advertising budgets and the Joint Program is budgeted for \$33,011,000.

Do you think that joint advertising produces better results for any one service—that is, does a general advertisement cause more people to enlist in the Navy, for example, as opposed to the Army?

Answer. There is no conclusive data to suggest that Joint advertising produces better results for any one Service or that Joint advertising causes more people to enlist in one Service over another. A Rand Corporation evaluation of the effectiveness of Service and Joint advertising suggests that Joint advertising may benefit the Navy more than it does the other Services, but the estimate is imprecise and definitive conclusions cannot be drawn.

QUESTIONS FOR THE ARMY SUBMITTED BY SENATOR BYRD

SERGEANTS MAJOR

Question. Historically, Sergeants Major have been a vital link in the chain of command. Recently, they have come under a substantial amount of criticism. Attention to the problem, brought about as a result of two articles in the Army's War College

publication "Parameters," has created a great deal of controversy in the services in general. Critics contend that the Sergeants Major have taken advantage of the system of perks and benefits. In addition, the relations between Sergeants Major and some officers have been strained due to the alleged excesses of Sergeants Major at the command level. Some have charged that the problem lies in the structure of the system. Others contend that it is a personnel and management problem in which a few individuals take unfair advantage of their positions as Sergeants Major. Would you please outline the problem as you see it.

Answer. There is absolutely no problem with the structure or the management system for Sergeants Major in the Army. Sergeants Major in the Army are accountable to, responsible to, and, in most cases, directly supervised by field grade or general officers. It is absurd to believe that our most qualified and experienced Officers would allow anything other than total professionalism and dedication from the enlisted Sergeant Major under their supervision. In the event of position abuse by a Sergeant Major, as alluded to in the article of the Army War College publication *Parameters*, appropriate actions are taken by the chain of command. However, such instances are isolated and they have little impact on the Army and our soldiers.

Question. What can be done to address these problems?

Answer. Commanders have the necessary administrative and judicial tools available to them to deal with any situation of abuse of position by Sergeants Major or soldiers of any other ranks.

Question. Are legislative solutions practical or necessary?

Answer. No.

QUESTIONS FOR THE ARMY SUBMITTED BY SENATOR BUMPERS

COLA: CATCH-22

Question. You make a useful argument when you point out in your prepared statement that the COLA for overseas posts is caught in a catch-22 situation, with families being forced to stay on base more because of the lag in the COLA, so that surveys reflect this (p. 6 of the statement). Is it possible to document this from Army survey data? It makes a lot of sense to me.

Answer. The Living Pattern surveys, which determine where and in what quantities members purchase their goods and services overseas, are conducted by the staff of the Per Diem, Travel and Transportation Allowances Committee.

Although existing survey data does not support this premise, my belief is that a catch-22 situation exists.

FUNDS FOR ENLISTED PERSONNEL

Question. If there were any extra funds to be made available for enlisted personnel purposes, and you could only choose one area to spend them in, would you spend it on housing, or medical treatment, or what?

Answer. While it is difficult to choose just one area, paying for the promotion of NCOs to the level authorized by our current structure would pay the greatest dividends in terms of morale and well being of the enlisted force. Were funds available above the level needed to buy back these NCOs they should be focused on continued recruiting of a quality force and improved quality of life issues such as pay comparability.

RECRUITMENT AND RETENTION

Question. Given the recent further drop in the unemployment rate, do you see the tightening of the labor market being reflected in recruitment and retention of enlisted personnel?

Answer. The Army has been experiencing a shortfall in obtaining the required number of quality contracts over the last 2 years. The fiscal year 1988 accession mission was accomplished in spite of a ten percent shortfall of the contract mission. This occurred at the expense of the delayed entry pool for the third consecutive year. The delayed entry pool is at its lowest level in 7 years and unless the trend is reversed, it will be impossible to maintain our quality accessions in fiscal years 1989 and 1990. The number of high quality contracts written declined twenty percent from 1986 to 1988. The reason for the loss is a difficult recruiting market characterized by higher youth employment and a declining youth population. Each reduction in unemployment or increase in private sector wages increases the challenge of recruiting a quality force. The fact that the Montgomery G. I. Bill. benefits, Army Col-

lege Fund kickers, and enlistment bonuses have not been increased since implementation in 1985, and major reductions in funding these programs have occurred, aggravates this problem. The rate of inflation of education has eroded the value of the GI Bill and Army College Fund kickers. The face value of the package has diminished by almost one third since 1985. Efforts are underway to increase incentive levels and to implement new enlistment options to expand the recruiting market. The reduction in recruiting resources (to include advertising) plus restrictions on utilization of the 2 year Army College Fund offer are significant reasons for our current recruiting difficulties. We see no problem recruiting sufficient quality soldiers for the Army if incentive and advertising levels are restored and funded. Our past recruiting experience has indicated that the recruiting market is not supply constrained and that with adequate resourcing our mission is attainable. Ironically, while difficulty has been encountered in recruiting new soldiers, there is no indication at this time of a retention problem. In light of the robust economy, close attention is given to retention. The high reenlistment rate indicates high levels of job satisfaction in the exciting and challenging environment of the U.S. Army. The high quality soldiers recruited in recent history have created an Army characterized by professionalism and fostered an environment where good soldiers want to reenlist. We will continue to monitor the retention program closely as we improve our recruiting efforts in this expanding economy. Provided that the current retention incentives are maintained, no retention problems are anticipated at this time.

QUALITY OF LIFE

Question. The current budget deficit is working a real hardship on the defense budget. Are there any low cost measures that can be undertaken that would have a significant positive effect on our enlisted personnel's quality of life?

Answer. Low cost, high payoff measures that have a significant positive effect on our soldiers' quality of life are currently being taken and will continue to be sought as a result of soldier and family member input during program development and feedback on quality of services through the use of installation human resources councils, town hall meetings, program councils, mayoral programs and/or installation family symposiums. Many issues that surface at these forums are resolved locally and do have a significant impact on quality of life of the entire force. Unresolved issues are forwarded by installation representatives to their MACOMs where they are addressed through MACON action plans. Those issues requiring action on an Armywide level are forwarded yearly from each MACON to HQDA. At the annual HQDA Family Action Plan Planning Conference soldiers, family members, and staff from communities, MACOMs and HQDA review and prioritize issues to be considered for the HQDA Family Action Plan. Specific guidance has been forwarded to the field to ensure that single/ unaccompanied soldiers are included on community councils and their concerns are considered. Through this AFAP process, driven by direction of the AFAP General Officer Steering Committee, shortfalls in Army programs are made known, converted into attainable issues, and acted upon until improved programs are in place, or the proposed enhancements, prove incapable of completion. Issues are prioritized and those issues that contribute positively to the Army goal of readiness and retention of quality soldiers and families are considered to be in the top priority category and are disseminated to the field. Budgetary limitations have forced the Army and its installation commanders to develop low or no cost initiatives to enhance existing programs. Many good ideas have been implemented, mostly at the installation/unit level. Some examples of low cost programs are: security deposits for utilities and rent, access to excess government furniture by hand receipt, consumer affairs and financial planning for soldiers, family member participation in housing activities and family member support groups at unit level.

QUESTIONS FOR THE ARMY SUBMITTED BY SENATOR D'AMATO

BASE CLOSURES AND REALIGNMENTS

Question. The Defense Secretary's Commission on Base Realignment and Closures has recommended the closing of fifty-two stand-alone housing installations throughout the country (five are in New York). In light of the emphasis each of our witnesses has placed on the issue of housing, I'd like to ask if any of them was consulted by the Base Closures Commission and what their comments are on this proposed action.

Answer. No, I was not personally consulted by the Defense Secretary's Commission on Base Realignment and Closures. In regard to the proposed closures of the

housing sites, as the Secretary of the Army has stated, we feel the closure of the sites will not impact on the Army's ability to accomplish its mission. While the closure of these sites may impact some service members more than others, on the whole we feel the Army will be able to save money and the soldiers will be able to find adequate housing in the affected areas.

VARIABLE HOUSING ALLOWANCE

Question. Certain notable duty stations in the United States, such as New York City, put unusually severe demands on the financial resources of service members due to the high cost of living there. What changes to the variable housing allowance system would compensate for these extremes?

Answer. Under the current variable housing allowance system, the out-of-pocket housing expenses for a soldier is approximately the same, regardless of his duty location. According to statistics, a soldier in New York City has the same out-of-pocket housing expenses as he would if he were stationed at Fort Sill, Oklahoma. This is supported by the New York City cost data available from a limited population, primarily recruiting personnel.

A variable housing allowance is an essential and cost effective complement to basic allowance for quarters. If the program is allowed to function as enacted into law, an appropriate total housing allowance could be provided which is responsive to the needs of all our members in all locations. This requires that the VHA system be free to operate without funding ceilings which have historically held the total housing allowance below the reasonable and documented expenses incurred by military personnel. The same applies to the basic allowance for quarters since continued funding restraints contribute to the soldier absorbing 20 percent of his total housing costs versus a goal of 15 percent.

Question. How much will an uncapped variable housing allowance revision cost annually? Would it be more cost effective in some areas to build new military housing facilities rather than rely on existing civilian housing?

Answer. The fiscal year 1989 costs for uncapped variable housing allowance would have been \$1.309 billion, which is \$89 million above the \$1.22 billion appropriated for fiscal year 1989. Since the programs' increases are limited to the annual housing cost growth, the denials of these increases in 1987 and 1988 have resulted in the inability to again reach the 80 percent base level without additional legislation.

With regards to the building of new military housing, the Department of the Army, in consonance with Department of Defense policy, depends primarily on the availability of housing on the local economy before construction or leasing. Due to numerous constraints, it is generally costlier to build, operate and maintain military housing facilities than to pay the basic allowance for quarters, and variable housing allowance to soldiers, who are expected to absorb a certain amount of their own off-post housing costs under the current compensation system.

QUESTIONS FOR THE NAVY SUBMITTED BY SENATOR INOUE

IMPROVING MEDICAL CARE FOCUS

Question. For many years, I have closely followed the performance and effectiveness of the medical facilities and services provided by the Department of Defense. In spite of significant increases in expenditures, I remain concerned about access to health care and the cost of CHAMPUS to the service member for dependents.

Gentlemen, from your perspective, where should we focus our efforts in improving the provision of medical care to service members and their families—in DoD medical treatment facilities or into reducing co-payment costs of CHAMPUS?

Answer. Both CHAMPUS and the Medical Treatment Facilities (MTFs) are important elements of our military healthcare system. Our efforts are primarily focused on providing healthcare in MTFs through direct support health services contracts, sharing agreements with the Veterans Administration, and partnership agreements. Other elements of healthcare delivery include CHAMPUS, CHAMPUS Reform Initiative, Uniformed Services Treatment Facilities, and supplemental care. From the Navy perspective, the focus involves total catchment area management to use all these elements to provide the required healthcare at the lowest cost. In some areas, where there is a minimum civilian medical infrastructure, we emphasize care in the MTF.

In other areas where we cannot provide direct support and where the civilian healthcare market is competitive, we emphasize contracting and partnership agreements, as well as CHAMPUS. Catchment area management requires involvement of

all the stakeholders, including the local medical establishment, beneficiaries and the Navy to ensure outcomes acceptable to all. It requires easy access to healthcare management information, which is to be provided by Defense Medical Systems Office and the individual military services.

Catchment area management is the military medical equivalent of product-line management, which is used successfully in civilian healthcare corporations to ensure fiscal responsibility and satisfaction of customer requirements. It is the challenge of the present for Navy medicine and our beneficiaries. Navy is beginning to practice catchment area management to expand access to care and to obtain the best mix of healthcare sources for each particular area.

MOST FREQUENT MEDICAL FACILITIES PROBLEMS

Question. What are the most frequent complaints or problems that service members or their families raise concerning care at DoD medical facilities?

Answer. From my visits to the fleet, the most frequent complaint voiced by our sailors is their inability to secure timely treatment for family members in a military medical treatment facility. After this, the most frequently voiced complaints are length of time to get appointments for family members, possibility of having to pay User Fees and the need to carry supplemental CHAMPUS insurance.

During Chief of Naval Operations's Retention Team visits to Medical Treatment Facilities, the most common complaints or problems raised are (1) limited access available for treatment, (2) frustration with the CHAMPUS system caused by inconsistencies and delays for payment and (3) the proposal to impose User Fees for outpatient care for dependents and retirees.

These concerns are being met by significantly increasing the staffing and support of Station Hospitals and Regional Defense Medical Facilities, establishing Family Practice Hospitals, and establishing health care finders to help beneficiaries find reasonably priced health care in the private sector. Additional contract support is increasing the quality and availability of inhouse and NAVCARE Clinics medical service while reducing the reliance on CHAMPUS services. The imposition of user fees is not supported at this time.

MODERNIZATION OF EQUIPMENT

Question. One of the areas we may be forced to reduce because of budgetary shortfalls may be continued modernization of equipment. Could each of you comment, from your perspective, if your services have the right equipment in the right amounts to perform your missions adequately?

Answer. Our Naval forces worldwide are taxed to the limit even with our modern equipment. I believe that recent Navy performance demonstrated during operations in the Persian Gulf and during the 1986 and 1988 operations in the Gulf of Sidra have shown both the adequacy and the need for the type and amount of modern weapons systems found on today's Navy ships and aircraft.

The recent advances in the capability and reliability of these systems has been made necessary by the evolving threat posed both by communist bloc and third world countries; most notably the threat of anti-ship and anti-aircraft missiles. These advances have been made possible and affordable by recent, dramatic advances in such technologies as propulsion systems and micro-circuitry.

In order to adequately operate our weapons systems, our sailors need and expect an adequate level of manning on our ships, training opportunities, freedom from worrying about family's quality of life while we are deployed, and an assurance that we will be able to rotate ashore on time.

PEOPLE OR WEAPONS HIGHER PRIORITY

Question. Do you think "people programs"—pay and benefits—should have a higher priority than new weapons acquisition?

Answer. Yes. It is imperative that we take care of our most important commodity, our personnel. Without the quality personnel in the Navy, we will not have the expertise required to use the sophisticated weapon systems of today. Quality of life issues are highly regarded by all personnel. We must be competitive with the civilian sector if the Navy is going to recruit and retain the high-tech people required. The standard of living for all personnel must be maintained by significant pay raises. Additionally, it is time to stop the perceived "erosion of benefits" that has taken place in the past few years, such as user fees for medical care, changes to retired pay, retired pay COLA cap, surcharges for commissaries and diminishing

educational benefits. By supporting "pay and benefits" programs, we will keep our best and brightest from seeking employment elsewhere.

MAINTAIN MISSIONS WITH FEWER PEOPLE

Question. If force structure were reduced, it might be possible to do both—buy and maintain new equipment and take better care of people. Do you think the military could fulfill their missions with fewer people?

Answer. I can't answer for the other services and to answer for the Navy is like looking into a crystal ball. Of course there are areas we could become more efficient in, but I honestly feel that we have cut to the point of inefficiency in several areas. Basic training is only eight weeks long, apprenticeship training has been reduced from four to three weeks and many "A" schools have been reduced in length. Our shore commands have been robbed to man our ships. All this shows up in our attrition and retention statistics. Cut ships and our people will have to deploy longer, cut people and our people will have to cross deck (transfer from ship to ship without a shore duty rotation) and deploy longer. Either way hurts the sailor, if our global commitments are not concurrently cut. Our ships are expected to be on all oceans, show the flag and be near possible up-risings to protect US interest and citizens. The sailor is carrying the burden; don't increase the load.

RECRUITING ADVERTISING

Question. Recruiting advertising is done both by the individual services and the Joint Recruiting and Advertising Program. For fiscal year 1990, the active services have requested \$124,399,000 for their advertising budgets and the Joint Program is budgeted for \$33,011,000.

Do you think that joint advertising produces better results for any one service—that is, does a general advertisement cause more people to enlist in the Navy, for example, as opposed to the Army?

Answer. Our field recruiters feel they are at a serious disadvantage in recruiting prospects because the Navy has such a small presence and the combined joint/Army television presence is so large. Although there is no immediate evidence to suggest that joint advertising alone causes more people to join any one service over another. Both the joint advertising program and the Army advertising program, however, have large media exposure.

The OSD sponsored "Youth Attitude Tracking Study (YATS)" completed in the fall of 1987 by the Research Triangle Institute studied enlistment propensity of target youth groups to include intentions and attitudes towards the military, advertising exposure and service image. Navy repeatedly ranked poorly, well behind the other services in recall of military advertising. Furthermore, when presented a list of 10 image statements, Army came to mind first on five of them which included: "provides money for education," "equal pay and advancement for men and women," "defending your country," "opportunities for promotion and advancement," and "work in or near a combat zone." Navy, despite being in the forefront of several military actions over the past few years, was known best for "extended duty away from family."

Navy's image needs to be improved. We are working internally and with OSD to make that happen.

MONEY SPENT ON SHIPS VICE SHORE FACILITIES

Question. Master Chief Bushey, it has been said that the Navy spends too much of its money on ships rather than shore-based facilities. Do you think this statement is correct?

Answer. "Too much" is hard to define. It's true that during the Naval buildup of the 1980's, most of our resources, including people, went into manning the fleet rather than keeping the shore establishments manned adequately. This was necessary because our end strength was not permitted to grow as originally planned. This does mean belt-tightening ashore with its negative impact on quality of life facilities, a trend we are trying to reverse with your help.

QUESTIONS FOR THE NAVY SUBMITTED BY SENATOR BUMPERS

IF EXTRA FUNDS WERE AVAILABLE

Question. If there were any extra funds to be made available for enlisted personnel purposes, and you could only choose one area to spend them in, would you spend it on housing, or medical treatment, or what?

Answer. I'd spend it on Bachelor Enlisted Quarters (BEQs) for our single sailors.

LABOR MARKET AND RECRUITING

Question. Given the recent further drop in the unemployment rate, do you see the tightening of the labor market being reflected in recruitment and retention of enlisted personnel?

Answer. There is no question Navy recruiting is more difficult today and will get tougher as we enter the 1990's. One of our principle objectives is to continue improving the Navy's image in the minds of our nation's youth. Allow me to briefly describe what we are facing. With the national unemployment rate falling to 5.0 percent in March 1989, taking a job in the military is generally given a lower priority by the 17-21 year old age group (who represent our primary market). This low unemployment rate is compounded by a declining manpower pool and a 10.1 percent civilian/military pay differential. The impact of these factors are clearly reflected in the following recruiting trends:

- The percentage of upper mental group people enlisting in the Navy is falling.
- While Navy has consistently made its total monthly recruiting goals, monthly enlisted nuclear field accession goals we missed January through March and non-prior service male accession goals were missed in February and March. We have fallen short of new contract objectives 12 of the last 15 months. The significance is we depend on new contracts to place people in the Delayed Entry Program for the out months.
- The Delayed Entry Program (DEP) is at its lowest level since 1981.
- Production per recruiter—or in other terms the average number of monthly enlistments per recruiter—is falling. This feature is a measure of the recruiting force's productivity and directly reflects the lower DEP posture.

These statistics, in effect, say life for the Navy recruiter is becoming more difficult as he must work harder to overcome the reduced numbers.

In order to counter this trend, we added in fiscal year 1989, 382 recruiters and 127 support staff. We have reviewed our staffing levels by geographic area and realigned 165 recruiter billets from the Northeast to provide additional support to areas of greater opportunity in the South and Southwest. Additional authority to enhance advertising efforts and increase Navy awareness is being pursued.

By the same token, the availability of jobs in the civilian sector has a definite impact on enlisted retention. Higher unemployment rates tend to keep individuals in the armed services while low unemployment rates make civilian life more attractive. Should future budget constraints prevent military pay and allowances from keeping up with the civilian wage levels, a strong civilian labor market will draw experienced sailors away from the Navy.

CURRENT BUDGET DEFICIT IS HARDSHIP ON DEFENSE BUDGET

Question. The current budget deficit is working a real hardship on the defense budget. Are there any low cost measures that can be undertaken that would have a significant positive effect on our enlisted personnel's quality of life?

Answer. Yes, several areas. We need to support the Morale, Welfare and Recreation facilities especially overseas.

Our Navy Family Service Centers (FSC's) must be fully funded. The counselor service has suffered because of year-to-year funding forcing our top quality personnel to seek jobs in the civilian market where they have more job stability.

There also are low cost measures that can be taken in the Child Care area. The following provides specifics:

(A) *Morale, Welfare and Recreation Program Low Cost Measures.*—In the area of morale, welfare and recreation (MWR) program operations and funding, there is one specific measure that, if approved for continuation, will have a significant and favorable impact on MWR program operations and financing. Termed the "appropriated fund (APF) reimbursement procedure," this procedure allows military MWR programs (recreational, food, beverage, entertainment services) to get optimal use out of the limited APF resources that presently provide supplemental support to these programs. The procedure allows base level MWR programs to "bill" the base

comptroller for costs that are already authorized APF support (e.g. MWR management salaries). By allowing MWR programs to employ people paid with internally generated MWR revenues (called nonappropriated funds e.g. fees and charges to patrons for the use of MWR facilities) and use the reimbursement procedure, the government gets more for its money. The reason is that the cost of a NAF paid employee that is eventually reimbursed with AP is less expensive than a direct hire civil service employee (due to lower wage scales for hourly paid employees and less expensive benefit plans). Maintenance of a NAF employee base (all but 2000 of the Navy's present 51,000 employees are NAF employees) with reimbursement also (a) avoids maintaining dual personnel systems (civil service and NAF) for large numbers of employees; (b) promotes career progression and upward mobility within the employee population; and (c) limits the impact on employees of switching back and forth between two personnel systems as employees move through their career paths.

As background, the FY-89 Defense Authorization Act directed termination of this procedure by October 1, 1990, because the Department of Defense (DoD) did not have a unified position among the four services (all but Air Force were using it prior to this year). Presently, all four services now use the procedure including the Air Force. Allowing continued use of this procedure costs nothing and allows military MWR programs to get more for the limited APF money they now receive. In these days of declining budgets and the need to be businesslike, procedures such as this are needed. I ask that the Congress endorse continued use of the procedure.

(B) *Family Support Programs.*—Navy Family Service Centers (FSCs) provide services including: information and referral; spouse employment assistance; money management; relocation and deployment; and counseling. These services directly affect the quality of life of servicemembers and families and are low cost; approximately \$23 million will be spent in fiscal year 1989 for 73 FSCs, headquarters staff, and program costs (including \$3.3 million DoD-provided family advocacy funds).

The 73 individual FSCs are funded from base operating support funds (BOS). Any reduction in BOS funds would be expected to produce commensurate cuts in FSC funding, making it difficult to sustain present program levels. Implementation of new programs has already been postponed.

The 1988 Family Support Conference recommended expansion of relocation, deployment, spouse employment and money management services. While these are relatively low cost initiatives, expansion would require additional BOS funding for personnel and program expenses.

DoD-provided funds for family advocacy (\$3.3M in FY 89) are allocated directly to local installations for salaries and associated program costs for prevention and treatment of family violence. Modest increases in these funds can be used to augment and/or sustain present preventative and counseling programs in the FSCs.

(C) *Child Care Low Cost Measures.*—In the Navy, there are an estimated 29,000 members with a child 5 years old or younger who need child care services. This includes 7,000 in dual military career families; 18,000 with a full-time employed spouse; and 4,000 single parents. We are currently able to meet half the requirement for child care through Navy child development centers and family home care (FHC) programs in government quarters. The majority currently served are in pay grades E4 to E6—those who have the most difficulty finding affordable care in the civilian sector. The remaining 14,000 children could be served through funding of low cost alternatives (listed below) to the building of child care centers (\$ in millions):

Purchase of interim facilities, \$8.7 (serve 2,900)—1 time cost; staff for interim facilities, \$2.9—annual cost; expansion of present child care centers, \$1.5 (serve 300)—time cost; 90 FHC monitors, \$2.3 (serve 6,800)—annual cost; Information and Referral Service (identify off base, affordable care alternatives), \$1.0 (serve 4,000)—annual cost; total, 16.4—\$10.2 (1 time cost), \$6.2 (annual cost).

QUESTIONS FOR THE ARMY SUBMITTED BY SENATOR D'AMATO

BASE REALIGNMENTS AND CLOSURES

Question. The Defense Secretary's Commission on Base Realignments and Closures has recommended the closing of fifty-two stand-alone housing installations throughout the country (five are in NY). In light of the emphasis each of our witnesses has placed on the issue of housing, I'd like to ask if any of them was consulted by the Base Closure Commission and what their comments are on this proposed action.

Answer. The Base Realignment and Closure Commission received considerable information from the Navy during their deliberations including information on Navy family housing assets and deficiencies. I personally was not involved in the submission of information to the Commission. None of the stand-alone housing installations recommended for closure are Navy assets. Consequently, their closure will not adversely affect the Navy's ability to perform its mission.

VARIABLE HOUSING ALLOWANCE COMPENSATION

Question. Certain notable duty stations in the U.S., such as New York City, put unusually severe demands on the financial resources of service members due to the high cost of living there. What changes to the Variable Housing Allowance system would compensate for these extremes?

Answer. The remedy to compensate for these areas with high cost of living does not necessarily lie in a revision to the VHA system but rather in instituting a Cost of Living Allowance (COLA) for the United States. As the concept of "differential pay" was recently recommended for Federal Civilian employees, a Cost of Living Allowance for service members certainly has merit. A COLA program in combination with a viable VHA program could help alleviate the financial burden on our members, especially our junior enlisted ranks, in these high cost areas.

Failing the passage of COLA, we need authority to prospectively set VHA rates in areas where the military population increases markedly, housing is very scarce or entry into the local housing market is restricted due to high costs.

UNCAPPED VARIABLE HOUSING ALLOWANCE ANNUAL COST

Question. How much will an uncapped Variable Housing Allowance revision cost annually? Would it be more cost-effective in some areas to build new military housing facilities rather than rely on existing civilian housing?

Answer. The cost of an uncapped Variable Housing Allowance (VHA) for DoD for FY-89 would have been \$1.309 billion.

It is the policy of the Department of Defense and the Navy to rely on the civilian community to provide housing for military personnel. It is only when the civilian community is unable to provide adequate and affordable housing that military construction of family housing is considered appropriate. This determination is made by the conduct of an annual survey which takes into account housing inventory, availability, cost and commuting distance.

Cost-effectiveness is a matter of perspective. From the point of view of the civilian community the answer is "no," since it is a loss of tax revenue and an increase in services such as schools. From the point of view of the military member the answer is "yes," since they forfeit BAQ and VHA while occupying government quarters and it normally requires more than those allowances provide to reside in the civilian community. From the point of view of the Navy it is an even trade-off if adequate housing is available. However, there are numerous locations in which housing deficits exist and these are not currently being met by either the civilian community or the government.

QUESTIONS FOR THE MARINE CORPS SUBMITTED BY SENATOR INOUE

MEDICAL ISSUES

Question. For many years, I have closely followed the performance and effectiveness of the medical facilities and services provided by the Department of Defense. In spite of significant increases in expenditures, I remain concerned about access to health care and the cost of CHAMPUS to the service member for dependents. Gentlemen, from your perspective, where should we focus our efforts in improving the provision of medical care to service members and their families—in DoD medical treatment facilities or into reducing co-payment costs of CHAMPUS?

Answer. We feel the most viable option should be the upgrading of service medical facilities. The emphasis should be on increased staffing of required billets in the Medical Corps and Nurse Corps. In addition, the upgrading of the medical facilities should include the addition of support personnel (admin, clerical and maintenance) to let the providers (doctors, nurses, corpspersons) concentrate on seeing more patients.

CHAMPUS is of course necessary to provide services for dependents in medically deprived areas, but we would advocate elimination of co-payment costs for those users. In addition to the above, we believe that the key to effective and efficient

health care delivery is emphasis on proactive measures. These measures include implementing programs dealing with the identification and treatment of hypertension; smoking cessation; back injury prevention; stress management; substance abuse, nutrition and weight control; and physical fitness and sports. Early identification of diseases such as hypertension and alcoholism could reduce health care costs before these conditions take their devastating toll. It is usually easier to prevent than to correct, and more cost-effective in the long run.

Question. What are the most frequent complaints or problems that service members or their families raise concerning care at DoD medical facilities?

Answer. The most frequent complaints that we have heard relate not to quality of care, but access to that care. Lengthy waiting times, both at primary care facilities and after being referred to a major medical center for specialized treatment, are a major problem. Once in the health care system, the service members and their families are generally pleased with the health care delivery service.

MARINE CORPS NCO RATIOS

Question. Sergeant Major Sommers, in a recent interview, Major General Donald W. Jones, Deputy Assistant Secretary of Defense for Military Manpower and Personnel Policy, said that the Marine Corps has "a perfect pyramid" of NCO strength, with the proper number of NCOs in each rank. Apparently, this was not true in earlier years.

What continuing actions does the Marine Corps take to make sure that NCO strengths remain in alignment?

Answer. The Marine Corps has institutionalized NCO strength alignment procedures through Enlisted Career Force Controls. These controls are a comprehensive force management plan which monitors and manages the number of Marines entering the Career Force [NCO]. As well as attempting to balance the Career Force inventory at the MOS level, Career Force Controls also works to standardize the level of experience (years of service) at each grade Marine Corps-wide. First term reenlistment constraints and lateral movement are two of the major tools used in aligning the Career Force.

Enlisted Career Force Controls, through the actions listed above, provides the commander with the right Marine in terms of grade and skill, the appropriate level of experience for each grade, and career equitability.

RECRUITING

Question. Sergeant Major Sommers, in last Wednesday's Washington Post, there was an article about a Marine recruiting scandal in the Pittsburgh area. Apparently, some Marine recruiters were guilty of falsifying information in order to obtain enlistments. According to the article, the recruiters responsible for the scandal are being punished. Do you think this was an isolated case, or are there indications that recruitment fraud has occurred in other locations?

Answer. We believe the incident in Pittsburgh was an isolated case, and is not indicative of the conduct of our overall recruiting force. There are no indications that there exists another case of recruiting impropriety similar to that uncovered in Pittsburgh.

Question. Is the Marine Corps meeting its recruiting goals so far in fiscal year 1989?

Answer. Yes, the Marine Corps is meeting its recruiting goals for fiscal year 1989.

Question. What controls does the Marine Corps have over its recruiters to prevent recruiting fraud from occurring again?

Answer. There is no guarantee that recruiting fraud will not occur. However, we have in place an established system which is designed to detect simple recruiter error as well as intentional fraud. It was this system that uncovered the problem in Pittsburgh and led to our immediate action to rectify the situation. This system, which has proven its capability to detect recruiting improprieties, ensures that our established enlistment standards are met and that we maintain the integrity of our recruiting service.

EQUIPMENT OR PEOPLE

Question. One of the areas we may be forced to reduce because of budgetary shortfalls may be continued modernization of equipment. Could each of you comment, from your perspective, if your services have the right equipment in the right amounts to perform your missions adequately?

Answer. The nature of Marine Corps missions and responsibilities requires a careful balance between our force structure, readiness, sustainability, and sufficient modernization to field capable weapons and equipment. Through the recent funding cuts we protected readiness as much as possible, partially through altering our force structure within a reduced manning level, slowing our sustainability growth, and limiting modernization to only that which is absolutely necessary.

The largest risk within the recent cuts is the loss in capability represented by the reduction in our actual and programmed manpower strength. We feel nothing we can do gives the return on the nation's investment that our people do. It was a difficult decision, but to strike a proper balance between the Marines in our force, their training, weapons, equipment, and their support through housing and working conditions, we felt it necessary.

The Marine Corps today is well equipped, due in large measure to our planning in the 1970s that provided the foundation for our modernization in the 1980s.

Question. Do you think "people programs"—pay and benefits—should have a higher priority than new weapons acquisition?

Answer. "People programs," including more than pay and benefits, are very important to the Marine Corps. We can recruit and retain those Americans that we want and need when we provide our Marines meaningful missions, challenging and purposeful training, good equipment, and proper working conditions. This must be backed by demonstrated concern for the individual and his family, shown through proper living conditions, readily available religious programs, medical care, good schools, and personal care for the Marine's family while he is deployed.

In short, our "people programs" cover everything within the purview of concerned, enlightened leadership. Pay and benefits are a part of how we demonstrate concern for our Marines, and we welcome efforts to keep military compensation commensurate with the civilian sector. But, we also feel that the type of Marines we have now, and expect to have in the future, are not in our Corps for monetary compensation alone. We must take care to ensure the balance between our mission, our equipment, and the care we provide our Marines and their families is maintained.

Question. If force structure were reduced, it might be possible to do both—buy and maintain new equipment and take better care of people. Do you think the military could fulfill their missions with fewer people?

Answer. The Marine Corps is more force-structure intensive than any other service. Of that, the vast majority of our force structure is our Marines, our manpower. As mentioned above, we feel nothing gives us, and the country, the return on our investment that our people do. In very real terms, our capability is our people.

It is difficult to determine whether we could accomplish our missions with fewer people. But, in an environment where our forces are already tasked with multiple commitments through various Unified Commander Operations Plans, fewer people equals greater risks.

As the smallest of the services, with extensive forward-deployment commitments, cuts to Marine Corps strength and force structure have a greater impact than might otherwise be the case.

Before decisions to reduce force structure are taken, I recommend consideration of the following factors.

Our manpower capability, or strength, recovers slower from a cut than any other capability. Those personnel, both officer and enlisted, not recruited in a given year become vacancies, with concomitant loss of service and experience, at higher ranks for many following years. Our experience during periodic wartime expansion demonstrates this tendency in the extreme.

If a reduction is forced too quickly, it must be taken from accessions, junior enlisted, early termination of contracts, selective early retirement boards, and junior officers. This causes great force structure turbulence, creates an imbalance between junior and senior grades, and damages morale and esprit. The longer the planning time available, the greater these risks can be eased.

We are finishing the implementation of our last force structure realignment, caused by the previous reduction. Within this reduction, we realigned our force structure, reduced infantry battalions, and shifted assets between the active force and the reserves to better align ourselves to meet highly likely contingencies, while still retaining general war capability through the reserve establishment. In many ways, we've pulled our organizations through the eye of a needle to make these changes while still retaining our readiness. Imposition of another reduction will cause turbulence and inefficiencies in force structure, manning levels, and the training establishment.

Short or long term, an end strength cut similar to the last reduction will affect our ability to support our mission commitments from a solid rotational base, and limit our ability to respond to various contingencies.

QUESTIONS FOR THE MARINE CORPS SUBMITTED BY SENATOR BUMPERS

ENLISTED PERSONNEL SPENDING PRIORITIES

Question. If there were any extra funds to be made available for enlisted personnel purposes, and you could only choose one area to spend them in, would you spend it on housing, or medical treatment, or what?

Answer. I would place extra available funds into a special duty pay for those Marines who are forced to live on the economy while on such duties as recruiting or Inspector-Instructor. These young Marines living in large cities cannot afford rent, even parking and tolls to go to work become a problem for them. When we think of independent duty we often think of the recruiter, we seldom think of the young Marine that must be assigned to these areas to support recruiting or Inspector-Instructor.

UNEMPLOYMENT RATE IMPACT ON RECRUITING

Question. Given the recent further drop in the unemployment rate, do you see the tightening of the labor market being reflected in recruitment and retention of enlisted personnel?

Answer. It is difficult to quantify the exact impact of a change in the unemployment rate. However, a drop in the unemployment rate will have an impact on recruiting. Low unemployment coupled with the decline in the youth population certainly intensifies the competition between colleges, the labor market and the military for high caliber young people.

QUALITY OF LIFE

Question. The current budget deficit is working a real hardship on the defense budget. Are there any low cost measures that can be undertaken that would have a significant positive effect on our enlisted personnel's quality of life?

Answer. There are some low cost measures that can be undertaken which would have a positive effect on our enlisted Marines. I believe that each service has submitted such measures to the Department of Defense for inclusion in their Legislative Contingency package. This package includes such proposals as the reimbursement for parking/toll fees and travel allowance for directed overnight duty. Congressional approval and funding for such programs would be helpful.

It is unfortunate that those measures which could have a significant positive effect on our enlisted personnel's quality of life (e.g. adequate pay increase in the elements of Regular Military Compensation, increased funding for base housing, and increases in the SRB program) are high cost items, not compatible with the current fiscal climate.

QUESTIONS FOR THE MARINE CORPS SUBMITTED BY SENATOR D'AMATO

BASE CLOSURE

Question. The Defense Secretary's Commission on Base Realignment and Closures has recommended the closing of fifty-two stand-alone housing installations throughout the country (five are in NY). In light of the emphasis each of our witnesses has placed on the issue of housing, I'd like to ask if any of them was consulted by the Base Closure Commission and what their comments are on this proposed action.

Answer. The Base Closure Commission did not consult with the Marine Corps on this issue during their deliberations.

VARIABLE HOUSING ALLOWANCE SYSTEM

Question. Certain notable duty stations in the U.S., such as New York City, put unusually severe demands on the financial resources of service members due to the high cost of living there. What changes to the Variable Housing Allowance system would compensate for these extremes?

Answer. The system is designed so that a service member anywhere in the country, regardless of rank or dependency status, has the same out-of-pocket housing costs. Some of the additional expenses that make these high cost areas difficult include such things as auto insurance rates, most home maintenance costs, and other factors not considered in setting VHA rates. Rather than change the system to meet these unique situations, I would prefer to see the current funding cap removed and the program funded as designed. This would provide the greatest good for the greatest number of our Marines.

UNCAPPED VARIABLE HOUSING ALLOWANCE SYSTEM

Question. How much will an uncapped Variable Housing Allowance revision cost annually.

Answer. It would cost an estimated \$40M annually to fully fund for Variable Housing Allowance.

Question. Would it be more cost-effective in some areas to build new military housing facilities rather than rely on existing civilian housing?

Answer. Unequivocally, yes. We believe that the Marine Corps' family housing is a self-supporting operation. Assuming a 98% occupancy rate and average BAQ/VHA rate of \$450 per month, the Marine Corps' inventory of 22,000 family housing units represents a BAQ/VHA cost avoidance of about \$116.4M per year. The Operation and Maintenance Budget for Marine Corps family housing was \$114.3M in FY88. While each construction project must be evaluated individually on its own merits, construction of new military family housing is probably the most prudent course of action at locations where government land is available and off-base housing costs generally exceed a Marine's BAQ/VHA.

QUESTIONS FOR THE AIR FORCE SUBMITTED BY SENATOR INOUE

MEDICAL ISSUES

For many years, I have closely followed the performance and effectiveness of the medical facilities and services provided by the Department of Defense. In spite of significant increases in expenditures, I remain concerned about access to health care and the cost of CHAMPUS to the Service member for dependents.

Question. Gentlemen, from your perspective, where should we focus our efforts in improving the provision of medical care to service members and their families—in DOD medical treatment facilities or into reducing co-payment cost of CHAMPUS?

Answer. We should focus our efforts on increasing access to medical care for service members and their families in DOD medical treatment facilities for the following reasons:

Patient Satisfaction. Our patients tell us they prefer to get their medical care at our military medical facilities. However, they would be more satisfied with our services were we better staffed to meet their needs. Insufficient availability of services due to specialty and support staff shortages was the number one dissatisfier among over 22,000 patients responding to a recent Air Force Health Care Survey.

Decreased Financial Barrier to Care. Patients who are disengaged under the provisions of CHAMPUS often view this as a reduction in their health care benefit. In reality, dependents of active duty face about the same out of pocket costs for inpatient care under CHAMPUS as in the direct care system hospitals. However, outpatient care under CHAMPUS involves an annual deductible and a 20 percent cost share for the patient. These costs especially burden the young military families living in areas remote from military medical facilities.

Cost-effectiveness. Generally, it costs less to provide care within our military medical facilities than under the cost sharing provisions of CHAMPUS. This is because we have fixed assets already in place to support the operational mission. Maximizing the use of those assets during peacetime will allow us to deliver services more efficiently. Recruitment and retention of sufficient providers and support staff is key to meeting that objective.

Wartime Medical Requirements. By providing health care with military providers, we are better prepared to meet wartime contingencies. Treatment of our full range of beneficiaries provides the training base critical to maintaining the skills of our personnel.

Quality Assurance. Today, CHAMPUS providers are not required to have malpractice insurance or meet our quality assurance standards. They only have to have a State medical license or meet certain professional requirements. The Air Force's quality assurance program is recognized as one of the best in the nation. When

demand is beyond our capability, we make every effort to assist or arrange necessary care for our patients with civilian providers who meet our own exacting quality standards.

To meet our patients' growing health care needs, we continue to aggressively pursue initiatives to improve access. We have three PRIMUS clinics in operation with others planned in the near term; we have over 260 Partnership agreements, and a number of projects to expand or establish services in our facilities under the Congressional Efficiency Add and Alternate Use of CHAMPUS Funds Programs. I appreciate your continued support of our efforts to increase access to the direct care system.

Question. What are the most frequent complaints or problems that service members or their families raise concerning care at DOD medical facilities?

Answer. The following comments are based on an extensive patient satisfaction questionnaire conducted by the US Air Force Medical Service during the period August-November 1987. Responses were received from approximately 23,000 beneficiaries visiting 118 of 121 total Air Force medical treatment facilities. While 85 percent of the respondents were satisfied or very satisfied with their overall care, four areas of concern were identified:

Lack of services available, parking, appointment system, and retirees want more dental care.

1987 Health Care Survey administration included mailing the survey to a random sample of beneficiaries living in the catchment areas of eight AF MTFs. An added benefit of the mail out survey was our opportunity to do a content analysis of the written comments made by more than one-half of those responding. Positive responses ranged from "outstanding" to "okay" and often mixed global comments about "good care" during an entire career with specific comments about a recent particular episode of care. Critical responses ranged from "deplorable" to "it's the care you are not providing that is the problem," and were more frequently related to specific aspects of care or to survey items.

From beneficiaries who made comments on the mail out survey, comments could be classified into six categories, four of which were primarily critical: Access (appointment system, waiting for appointments, waiting in clinics to see the provider); MTF Resources (understaffing, lack of services, inability to get prescriptions filled); retiree treatment (perception of retirees as "betrayed" or "treated as second class citizens" once no longer on active duty); and process/system ("the system is not responsive") We are continuing to assess patient satisfaction on an annual basis to ensure we stay in touch with our patients needs and concerns.

EQUIPMENT FOR PEOPLE

One of the areas we may be forced to reduce because of budgetary shortfalls may be continued modernization of equipment.

Question. Could each of you comment, from your perspective, if your services have the right amounts to perform your missions adequately?

Answer. From my visits to the field, the troops feel they have the right equipment to get the job done. This is due to our modernization efforts over the last 8 years. It's extremely important we continue our efforts to modernize to accomplish the missions we'll have to meet in the 90's.

ENLISTED PERSONNEL ISSUES

Question. Do you think "people programs"—pay and benefits should have a higher priority than new weapons acquisitions?

Answer. Our people programs are designed to attract and retain sufficient numbers of quality people to ensure readiness. With that objective in mind, yes—"people programs" should be our number-one priority, especially given the current overall environment. It takes the quality, experienced people to operate the weapons, new or old.

EQUIPMENT OR PEOPLE

Question. Do you think the military could fulfill their missions with fewer people?

Answer. The Air Force recognizes manpower as a resource like dollars, not as a program or as force structure in itself. As a resource, when programs are increased or decreased, manpower required to support the program should be appropriately increased or decreased. By this means, the Air Force avoids disconnecting a program from the resources required to support the approved program level. Additional end strength reductions could only be effectively accomplished through further re-

ductions to the force structure; that is, missions would likely have to be restructured or eliminated. It is clear that such actions would increase risk to the nation.

RATIO OF NCO'S TO JUNIOR ENLISTED

Pentagon figures indicate that noncommissioned officers in the top five pay grades currently account for 41.6 percent of the enlisted Army, 45.5 percent in the Navy, 48 percent in the Air Force, and 31.5 percent in the Marine Corps.

Question. Chief Binnicker, what effect does having such a large percentage of senior people have on promotions?

Answer. Low retention during the late 1970's was followed by force structure growth in FY80-82. This led to several large accession cohorts and, with retention improving, greater numbers of enlisted personnel began to enter the career force. All the Services have enjoyed excellent retention during this decade. The Air Force has generally set the pace due, in part, to having a different mission with more technically-oriented career fields offering an attractive array of training opportunities. The improved retention environment of the 1980's can be attributed to several factors: renewed pride in serving in the military and the success of the All-Volunteer Force are but two. This retention picture also led to more experience among the noncommissioned officers (NCOs). To ensure that these NCOs have some reasonable expectation of career progression, a grade plan with a Top-5 content of 48 percent is necessary. Even with this level of Top-5 grades, promotion pin-on times for Air Force NCOs will slip to later points in terms of years of service. It is interesting to note that Air Force NCOs already pin on two years later, on the average, than NCOs in the other Services. There is no doubt that increased experience levels have been beneficial to the Air Force. The Air Force has a better trained, equipped, and more committed force than perhaps at any time in its history. As the Air Force moves into a more uncertain future of the 1990's, this experience factor will provide a "safety net," should additional strength reductions, tighter budget constraints, and potential shortages of technically qualified recruits become a reality.

Question. The Marine Corps also flies and has to maintain sophisticated aircraft. Why does the Air Force apparently require such a top-heavy enlisted force, when the Marine Corps manages with a much smaller percentage of senior NCOs?

Answer. It is very difficult to compare the enlisted forces of the Marine Corps and the Air Force because roles and missions are quite different. The Marine Corps depends on its enlisted force primarily to fulfill its ground combat mission, which, by definition, requires a lower grade (younger) structure. The Air Force, on the other hand, uses its enlisted force to maintain and manage its highly technical force of aircraft and missiles. The effect of mission on enlisted structure can best be seen by comparing seniority in the Marine Corps' aircraft maintenance specialties to the Air Force's seniority. In their fixed-wing enlisted maintenance structure, the Marine Corps, in the top-5 grades, is better than 50 percent richer than the Marine Corps as a whole and has a percentage of top-5's approximately equal to the Air Force's overall percentage of 48 percent.

ADVERTISING

Recruiting advertising is done both by the individual Services and the Joint Recruiting and Advertising Program. For fiscal year 1990, the active services have requested \$124,399,000 for their advertising budgets and the Joint Program is budgeted for \$33,011,000.

Question. Do you think that Joint Advertising produces better results for any one service—that is, does a general advertisement cause more people to enlist in the Navy, for example, as opposed to the Army?

Answer. A March 1989 study by RAND Corporation, entitled "The Effects of Military Advertising: Evidence from the Advertising Mix Test," concluded that both Joint and total Service advertising are effective for increasing high quality active enlisted force enlistments for all Services. However, individual Services are affected differently by shifts between Joint and Service advertising. The data revealed that for the Army, Joint and Army advertising are equally cost-effective. The empirical estimate for Navy advertising was too imprecise to draw any firm conclusion about Navy advertising effectiveness. However, Joint advertising is important to the Navy. While the effects of Joint and Marine Corps advertising on Marine Corps recruiting are not statistically different, the data suggests that the Marine Corps advertising may be more cost effective. On the other hand, Air Force advertising does more per dollar for the Air Force than Joint advertising.

The Air Force position continues to be that Joint or "corporate" advertising should complement Service advertising by focusing on general awareness messages

targeting influencers, not prospects. Independently, each of the military services needs to foster its own identity within specific segments of the marketplace.

In the final analysis, Air Force advertising gets more bang-per-buck than Joint advertising and is more effective for the Air Force than Joint. Thus, relative small increases or decreases can drastically affect Air Force awareness in the local community.

QUESTIONS FOR THE AIR FORCE SUBMITTED BY SENATOR BUMPERS

FUNDS AVAILABLE FOR ENLISTED PERSONNEL PURPOSES

Question. If there were any extra funds to be made available for enlisted personnel purposes, and you could only choose one area to spend them in, would you spend it on housing, or medical treatment, or what?

Answer. Within the funds allocated, we achieve a balance among our programs such as housing and medical treatment. However, if we're talking about extra dollars, its probably a small amount and to achieve an improvement in medical treatment, it would take more than small dollars. Therefore, I'd prefer these dollars go into housing for the junior enlisted troops, both dormitory and military family housing for E-1 to E-3

DROP IN UNEMPLOYMENT RATE

Question. Given the recent further drop in the unemployment rate, do you see the tightening of the labor market being reflected in recruitment and retention of enlisted personnel?

Answer. Air Force recruiting is experiencing some regional difficulty in achieving enlisted recruiting goals, specifically in the Northeast and on the West Coast. A portion of this difficulty can be attributed to improved economic conditions. Overall it is difficult to gauge the true impact of recent employment rate changes. Air Force total accession levels are well below the norm. Typically the Air Force recruits in the 55,000 to 65,000 range of new recruits per year. Due to congressionally mandated budget limitations and end-strength reductions, Air Force accessions are currently in the mid-40,000 range—well below the point where market-imposed restrictions would be noticed. Further, Air Force opportunities have traditionally appealed to those seeking increased educational and training opportunities. Even with a higher level of employment, young men and women seek out the Air Force as a avenue for self-improvement.

ENLISTED PERSONNEL ISSUES

The current budget deficit is working a real hardship on the defense budget.

Question. Are there any low [cost] measures that can be undertaken that would have a significant positive effect on our enlisted personnel's quality of life?

Answer. Significant positive effects on quality of life cannot always be made with "low cost" enhancements; sometimes it takes relatively large budget outlays just to maintain the status-quo. Two prime examples are the proposed 3.6, military pay raise for FY90 and the requested Variable Housing Allowance (VHA) appropriation which reflects national housing cost inflation. Even with the proposed 3.61 pay increase, comparability would fall farther below civilian levels to approximately -10.8. The requested VHA appropriation would prevent out-of-pocket housing costs from increasing further; it would not at all reduce this percentage from the current 21.5, to the statutory objective of 15 percent.

Several low-cost initiatives are included in the FY90/FY91 budget that would reduce some members' out-of-pocket expenses and indirectly contribute to improved quality of life. One proposal authorizing travel allowance for directed overnight duty within duty station limits. A second is the reimbursement of parking fees, road tolls, etc. incurred by the individual when using his/her own vehicle on temporary duty (when more advantageous to the government). Both of these initiatives reduce additional out-of-pocket expenses incurred by certain personnel accomplishing their prescribed duties.

Another initiative in the FY90/FY91 budget which is designed to reduce out-of-pocket expenses incurred by official orders is the modified dislocation allowance (DLA). This measure would allow the member to receive up to a second month's DLA (equal to one month's basic allowance for quarters) if documented allowable expenses were incurred as a result of an official permanent change of duty station.

QUESTIONS FOR THE AIR FORCE SUBMITTED BY SENATOR D'AMATO

BASE REALIGNMENTS AND CLOSURES

The Defense Secretary's Commission on Base Alignments and Closures has recommended the closing of fifty-two stand-alone housing installations throughout the country (five are in NY).

Question. In light of the emphasis each of our witnesses has placed on the issue of housing, I'd like to ask if any or them was consulted by the base closures commission and what their comments are on this proposed action.

Answer. No, however this issue is being looked at very closely to assess the impact base closures will have on housing availability where missions and troops are being transferred.

NOTABLE DUTY STATIONS AND DEMANDS

Certain notable duty stations in the U.S., such as New York City, put unusually severe demands on the financial resources of service members due to the high cost of living there.

Question. What changes to the variable housing allowance system would compensate for these extremes?

Answer. The Variable Housing Allowance (VHA) system is already designed to provide compensation to members who are assigned to high cost areas. VHA rates vary by locality and are based on housing costs reported by members assigned to that location. The upper limit for VHA is set in law and may not be exceeded. However, when insufficient appropriations are made to pay VHA in accordance with the statutory formula, rates must be lowered to remain within the appropriation. Currently, VHA is not compensating our people as it should regardless of where they are assigned. The fundamental problem is not the system itself, but rather the funding shortfalls which Congress has built into the VHA program over the years.

The law provides that the Department of Defense may only increase the VHA budget over the previous year authorization based on two factors: 1) for inflation in nationwide housing costs as reflected in the housing component of the Consumer Price Index, and 2) for changes in force structure. Congress denied full inflation adjustments in fiscal years 1987 and 1988. Because we can only increase our budget request over the previous years authorization, we are unable to recover the ground lost to inflation in these years. As a result, VHA rates are lower than they should be, and members at all locations are absorbing a greater share of housing expenses out of their basic pay than they should.

The only answer to this problem is for Congress to insure the VHA program receives its needed full inflation adjustment this year and every year.

VARIABLE HOUSING ALLOWANCE

Question. How much will an uncapped Variable Allowance revision cost annually?

Answer. Uncapping VHA will have no effect on service VHA budget requests. Funding for the Variable Housing Allowance (VHA) program is revised annually in accordance with statutory provisions in title 37 sec 403a. The first provision is that fiscal year funding requests may increase in accordance with housing cost growth as measured by the housing component of the Consumer Price Index (CPI). The second provision allows for funding request changes due to changes in force structure (i.e., end strength, dependency changes, etc.) Thus, uncapping VHA will not result in uncontrolled increases in appropriation requests. For example, the FY90 PB requests an increase to the FY89 VHA authorization that will cover a 3.6 percent housing cost inflation increase and changes in DoD's force structure. Since uncapping VHA cannot increase an appropriation, a Service that has failed to accurately forecast its VHA requirements will be required to reprogram in order to pay its VHA bill. These additional VHA expenditures do not form part of the baseline for successive annual VHA budget requests.

SUBCOMMITTEE RECESS

Senator INOUE. We thank you for testifying before the subcommittee, and we will now recess until Thursday, March 16, at 9:30 a.m., when we will have the Assistant Secretary of Defense for Health Affairs, the Surgeons General, and the heads of the Service Nurse Corps to discuss health issues.

We now stand in recess.

[Whereupon, at 11:45 a.m. Tuesday, March 14, the subcommittee was recessed to reconvene on Thursday, March 16.]



DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 1990

THURSDAY, MARCH 16, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 9:33 a.m. in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senators Inouye, Stevens, and D'Amato.

DEPARTMENT OF DEFENSE

MEDICAL READINESS

STATEMENT OF WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE FOR HEALTH AFFAIRS

HEARING PROCEDURE

Senator INOUE. This morning the subcommittee will hear testimony on a critical wartime and peacetime mission of the Department of Defense, medical readiness. The hearing today will include three panels, recognizing critical elements in the health care leadership of the Department of Defense:

First, to speak on behalf of the Department as a whole, will be Dr. William Mayer, Assistant Secretary of Defense for Health Affairs. Dr. Mayer's role includes providing overall direction and guidance for health care programs and responsibility for CHAMPUS.

The second panel consists of the Surgeons General of the three military services: General Ledford of the Army, Admiral Zimble of the Navy, and General Miller of the Air Force.

Our third panel represents the nursing professionals in the military, and I am pleased to have the Chief Nurses of the services with us: General Adams-Ender of the Army, Admiral Hall of the Navy, and General Goodwin of the Air Force.

The past years have been a time of great challenge to those in the Department of Defense with the responsibility to meet the dual missions of medical readiness. It may interest some of you that a few days ago the senior enlisted men of all the services appeared before this subcommittee and each of them testified that, of the important matters concerning them, health care was No. 1 for themselves and their families.

CHAMPUS

Since 1984, the annual cost for CHAMPUS has grown from \$1.3 billion to over \$2.7 billion for fiscal year 1990. Every dollar directed to CHAMPUS subtracts a dollar that would otherwise go for readiness, training, and maintenance of equipment, or the sustainability of U.S. forces in time of war.

The growing deficit problem has forced the Congress to constrain funding for military activities. Yet, the cost of CHAMPUS continues to grow. In fiscal year 1988 alone, over \$600 million was reprogrammed from military functions to cover increased CHAMPUS costs.

Dr. Mayer has served as a key figure in the Department's effort to regain control over the rising medical budget. The initiatives discussed in your testimony, Mr. Secretary, and supported by this subcommittee have made tremendous strides in bringing order and control to CHAMPUS, and the subcommittee looks forward to your report this morning on where we stand today and where you look to go in the future.

The hearing will continue after our session with the Secretary. We will receive testimony from key military leaders of the medical services and DOD. The Surgeon Generals of the three departments have overall responsibility for the administration of military medical facilities, personnel, and resources provided for direct care.

NURSING CONCERNS

Equally critical to the availability of quality care in the military medical system is the nursing community in each of the services. I was surprised to learn that the Chief Nurses of each of the services had never before testified before any committee of the Congress, in spite of the many challenges they face in the conduct of their mission and the pressures to compete for personnel with the civilian sector. So this committee is pleased to afford them this opportunity this morning to present their concerns directly to the Congress of the United States, and I can assure you that this testimony will be a valuable part of our proceedings.

Now the subcommittee will hear from the Secretary. I wish to welcome you again, Mr. Secretary. It is always good to see you, and I would like to assure you that your full statement has been entered into the record, and you may proceed in any way you wish, sir.

Dr. MAYER. Thank you very much, Mr. Chairman.

Senator D'AMATO. Mr. Chairman.

Senator INOUE. I just noticed, my distinguished colleague from New York is here, and I am sure he has something he would like to present.

Senator D'Amato.

STATEMENT OF HON. ALFONSE M. D'AMATO, U.S. SENATOR FROM NEW YORK

Senator D'AMATO. Well, Mr. Chairman, first of all let me commend you for calling this hearing. And as you indicated, there is probably no area that has more concern than the area of health matters related to those of our personnel in the military service.

And there is a very unique opportunity for the country as a whole to benefit tremendously as a result of the kind of control that we have in the military and the health programs that are implemented. It seems to me, Mr. Chairman, that obviously one of those areas that is of great concern is the control of drug use and what effect and what impact the testing programs in the military have had.

I am not going to be able to be here past the hour of 10 because there are a number of other hearings, and so I do have three questions. I know the Defense Department is conducting random mandatory drug testing for all uniformed personnel and civilians in sensitive positions.

Maybe the Secretary could tell the committee what effect this program has had on drug use in the military and in the work force. I am wondering if the Secretary could describe to the committee the programs for drug education and treatment, what the policy is where there is someone who is ascertained to have utilized drugs.

In addition, do you believe that there are certain aspects of the antidrug program which has been developed which could be adopted for use in the civilian community? And what, if anything, have you done or will you be doing relative to bringing and sharing this information of the program and those aspects that work with our new drug czar, Secretary Bennett?

I think, Mr. Chairman, we have a unique opportunity to benefit from the experiences, both the positive achievements and some of the setbacks, as it relates to this important area.

Obviously, when we talk about drugs we also talk about the problem of AIDS, because a good percentage of AIDS comes about as a result of intravenous drug abuse. So this is, I think, a unique opportunity to share your results, because I honestly believe that if we are ever going to win this drug war, it is more than guns and bullets and laws. It is the kind of programs that the military has embarked on.

Thank you, Mr. Chairman.

Senator INOUE. I am certain the Secretary will respond to your questions after he has submitted his statement.

Dr. MAYER. I would be very happy to.

Mr. Chairman, Senator D'Amato, thank you both for your comments and for giving me the privilege of appearing before this committee.

COST OF HEALTH CARE

As you both commented, health care is a critically important part of our Defense Establishment. It has achieved enormous proportions. It is costing the Department of Defense approximately \$13 billion a year. It extends health care directly or finances it in part for nearly 10 million people.

We are admitting about a million people a year to hospitals, treating about 60 million outpatients. All told, this program has reflected many of the problems in civilian medicine, particularly those of cost and of staffing, but in addition has, as the Chairman indicated, the primary mission of medical readiness to go to war.

This year I have, I think, really good news to report to you, first with respect to our readiness problems, which were in abysmal shape just a few years ago; second, with respect to the quality of health care delivery in the Armed Forces, which is clearly and demonstrably far ahead of any other segment of medicine today; and third, we have engaged in a struggle with the devil of rising costs, and I think we are beginning to win it finally. Nowhere else in American medicine today is that happening.

MEDICAL READINESS

Medical readiness continues to be our primary mission. We are there to take care of soldiers and sailors and airmen and marines who get hurt or wounded in battle. It will continue always to be our first priority.

It is a dual project. It requires both the equipment and the personnel. Medical equipment that can be deployed, which we call DEPMEDS, was in disastrously short supply, having been drawn down both during Korea and during Vietnam and never adequately replaced.

That is largely corrected today. As of today, we have on hand or on order 75 percent of all the medical and surgical equipment we would need for a general global war.

It has all been tested. Much of it is prepositioned, and the construction that we are doing this year largely applies to places where we want to preposition medical supplies, since even a small field hospital takes a large airplane to transport it. We could not possibly move one overseas at the outset of a war.

In addition, we have more than 100 additional critically short specialists that are needed for wartime operations, particularly the surgical specialties and anesthesiologists. That is an 11-percent increase in the last 6 years.

There has been an even greater growth in the Reserve. We have a 57-percent increase in physicians in the Reserve forces and a 63-percent growth in the number of nurses in our Reserve.

Until 1986-87 we lacked an integrated worldwide medical readiness strategic plan. That plan is now in place. The command surgeons who are now in place both in Europe and in the Far East are charged with making certain that we can execute those plans, and we are more than halfway through with the several hundred objectives that are listed in the plan.

I am particularly grateful for the support of this committee in charging ahead with the development of such a plan and with the entire medical readiness improvement we have experienced in the last few years.

QUALITY OF CARE

No one on the committee, I am sure, can fail to recall the very difficult situation having to do with quality of medical care in the Armed Forces. This hit the press and was dramatized in the early 1980's. There were very serious questions about the quality of health care, and, in fact, it was beginning to erode the confidence our patients had in the doctors and other health professionals that treated them.

We have established in the Armed Forces what is unquestionably the most elaborate and effective medical quality assurance program that has ever been designed. Our civilian external peer review, in which we invite civilians/specialists to review more than 50 criteria of patient care that are very clearly outlined. This has proven to be a huge success.

Measured by explicit criteria against high-risk medical and surgical events, it turns out that less than 1 percent of all the cases treated in our hospitals fail to pass the initial screening or require further review.

An article in the American Medical Association in November outlined DOD's quality assurance program, and an accompanying editorial by the editorial staff of the Journal stated that this approach used by the Department of Defense is likely to diffuse throughout the civilian medical care system, because it has the potential to facilitate peer review that is more objective and cost effective.

If there is no objection, Mr. Chairman, I would like to submit this article and this editorial from the Journal of the American Medical Association.

Senator INOUE. Without objection, it will be made part of the record.

[The information follows:]

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A FIRST REPORT OF THE DEPARTMENT OF DEFENSE EXTERNAL CIVILIAN PEER REVIEW OF MEDICAL CARE

William Mayer, MD; J. Jarrett Clinton, MD; David Newhall III

In mid-1985, the Department of Defense announced a plan for an external civilian peer review of selected medical and surgical cases in military hospitals. A medical advisory panel consisting of practicing clinical representatives from nine medical specialty societies helped develop written criteria and standards for specific surgical and medical cases. Abstracted data were compared with computer algorithms created from the medical standards and criteria. Those cases failing the review criteria were reviewed by a physician peer review panel. The sampled medical records represented approximately 7% to 8% of the total hospital discharges. Less than 1% of the overall sampled cases were in non-compliance with stated standards. The highest rate of noncompliance was for cases of diabetic ketoacidosis. The most frequent noncompliance event was hysterectomy. Although comparisons are not available, the quality of care among selected cases, as measured by compliance with civilian physician specialty group-endorsed standards, appeared high.

(JAMA 1988;260:2690-2693)

IN EARLY 1986, the Department of Defense initiated a bold activity—the review, by civilian physicians external to the military, of the quality of medical care in the hospitals of the US Army, US Navy, and US Air Force. The purpose of this article is to describe the process of this review, the experiences to date, and the lessons learned. This information should prove useful to health care systems considering or implementing peer review programs.

DESCRIPTION OF THE MILITARY HEALTH CARE SYSTEM

The health care services available to approximately 9 million Department of Defense beneficiaries (active duty personnel, dependents of active duty personnel, retired military personnel, and their dependents) are provided in 168 hospitals plus approximately 500 free-standing clinics. These facilities provide more than 900 000 inpatient admissions

and some 47 million ambulatory medical and dental visits annually. Table 1 displays the military hospitals by location and current number of operating beds. On the average these hospitals have an occupancy rate of 80% and a length of stay of 5.4 days. Twenty-three percent are located outside the United States in 16 different countries. Of the total number of hospitals, 15 (9%) are medical centers with extensive graduate medical education programs.

RATIONALE FOR THE EXTERNAL PEER REVIEW PROGRAM

In the early 1980s, criticism of the quality of medical care in military hospitals led to substantial initiatives in medical care quality assurance. Among these Department of Defense initiatives were a validation and review of the credentials of physicians; development of criteria for granting clinical privileges; establishment of a licensing require-

ment for physicians, nurses, dentists, and seven other health care-provider professional groups; and the development of hospital-based, computer-assisted quality assurance programs that focused on the monitoring and evaluation of both medical events and health care providers.

Despite these quality assurance activities and other measures intended to enhance the quality of medical care, public and congressional criticism of medical care based on anecdotal events continued. Therefore, in mid-1985 the Department of Defense announced a plan for a civilian external peer review of selected medical and surgical cases. The intent was to review approximately 10% of the more than 900 000 hospitalizations within military hospitals per year. The program was planned to complement the internal hospital-based quality assurance programs by documenting the quality of care and identifying medical cases, hospitals, or health care providers where corrective interventions appeared warranted.

A secondary expectation of this project was that measurement against defined medical and surgical standards and criteria would provide useful comparisons of the quality of military medical care with similar evaluations in the civilian medical sector.

DESCRIPTION OF THE CURRENT PROGRAM

In January 1986, the Department of Defense awarded a contract for civilian peer review of military medical care. The clinical categories proposed for review were identified by the Department of Defense and are listed in Table 2. The percentages of cases selected were determined subjectively to be reasonably representative of the total cases and collectively represent about 15% of all hospitalizations in military hospitals. Reviews of the literature soon confirmed that nationally accepted medical care standards and criteria rarely existed for the diagnoses that were of interest to the Department of Defense. Therefore, to provide advice on criteria development and review activities, the contrac-

tor created a medical advisory panel consisting of practicing clinical representatives from nine medical specialty societies: The American College of Physicians, the American College of Surgeons, the American College of Obstetrics and Gynecology, the American College of Pediatrics, the American Academy of Family Physicians, the American College of Cardiology, the American Academy of Orthopaedic Surgeons, the College of American Pathologists, and the American College of Radiology. A second panel, the peer review panel, consists of licensed, board-certified physicians experienced in medical case review and practicing in their specialty. Department of Defense staff provided overall guidance for project implementation including the mechanisms for information flow between the hospitals and the external review process.

The external medical review system for the selected diagnoses indicated in Table 2 operates from explicit criteria and standards for medical care. These include the review of surgical appropriateness and the appropriateness of diagnostic and therapeutic interventions. At the present level of development and implementation, written criteria and standards for medical care have been created and used for the listed surgical and medical cases (Table 2) excluding the five principal diagnoses of cancer, status asthmaticus, congestive heart failure, meningitis, and cerebrovascular accidents. A defined data set for each criterion stipulates information to be collected regarding clinical treatment and findings that allow determination of whether the criterion was met. Two examples of these standards and criteria sets are provided in Tables 3 and 4.

The magnitude of this review process, employing uniform standards and an enormous volume of data, is unprecedented. To accomplish the task, traditional methods of review have been coupled with modern data-processing techniques to allow maximal use of computer analysis of data and highly focused review by the peer review panel of practicing physicians.

The review process begins by the mil-

Table 1. — Military Hospitals by Location and Number of Operating Beds

No. of Beds per Hospital	United States	Europe	Pacific	Caribbean	Total
1-25	23	10	3	1	37
26-99	62	10	4	1	77
100-199	24	2	3	1	30
200-399	12	3	...	...	15
400 +	9	...	...	...	9
Total	130	25	10	3	168

*An operating bed is defined as a bed that is currently set up and ready in all respects for the care of a patient. It must include supporting space, equipment, and staff to operate under normal circumstances. Nursery bassinets and transient patients' beds are excluded.

Table 2. — Medical Surgical Categories for External Peer Review Program

General inpatient review*
All readmissions within 14 d of discharge from prior hospitalization
All surgically related deaths
All cases of neurological deficit, not present at admission, related to anesthesia
All cases of organ failure that were not present at admission
All postoperative or procedure complications
Emergency services review*
All unplanned returns to the emergency department within 48 h of previous treatment
All patients dead on arrival at the emergency department where emergency transportation was the responsibility of the military hospital
All patients that die in the emergency department
All patients that die in the hospital, having been admitted through the emergency department
Surgical appropriateness review
20% of all primary cesarean sections
20% of all hysterectomies
20% of all cholecystectomies
20% of all transurethral resections of the prostate
20% of all coronary artery bypass grafts
20% of all cardiac catheterizations
20% of all carotid endarterectomies
20% of all femoral and aortic grafts
20% of all total joint replacements
20% of all laminectomies
Patient transfer review*
10% of cases transferred in from military referral hospitals reviewed for timeliness and appropriateness
High-risk diagnoses and continued inpatient review — all cases with the following 14 diagnoses:
Principal diagnosis of hypertension
Lung
Colon
Breast
Cervix
Prostate
Congestive heart failure/congestive heart disease*
Atrial fibrillation
Diabetic ketoacidosis
Status asthmaticus*
Meningitis*
Ruptured appendix
Acute myocardial infarction
Bone nonunions
Cerebrovascular accidents*
Neonatal and maternal deaths
Preeclampsia and eclampsia
Delivery of low-birth-weight infants, <2.5 kg

Table 3. — Hysterectomy Standards*

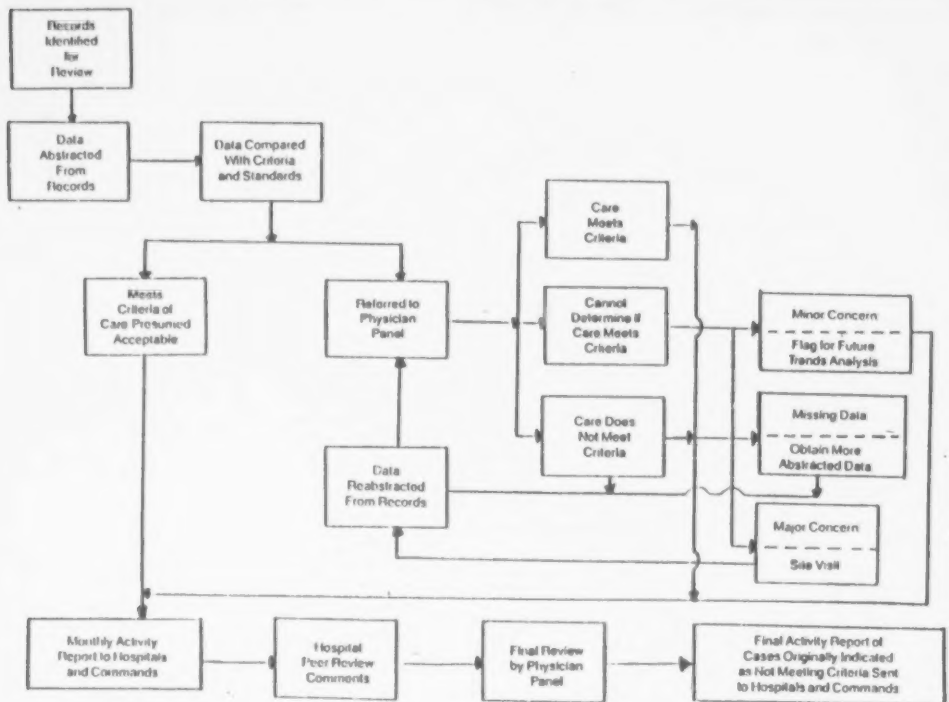
Hysterectomy Presumed Indicated
Surgery is presumed to be indicated if medical record shows any of the following:
If patient is >24 y, hysterectomy is presumed to be indicated for any of the following:
Preinvasive cancer of cervix, in situ "0," or cervical intraepithelial neoplasia
Cancer of cervix, stage I
Cancer of uterus (endometrium), stage I
Cancer of ovary, stage I
Fibroids (leiomyomata) in a uterus that:
Weights ≥ 0.35 kg
Is of the size of a ≥ 9 -wk pregnancy
Tubo-ovarian abscess
Prolapsed uterus and stress incontinence
Uterine rupture
Recurrent pelvic inflammatory disease and chronic pain characterized as severe, lasting ≥ 9 mo
Excessive uterine bleeding (menstrual flooding defined as menstruation > 8 d or if menstruation is < 8 d and hemoglobin is < 100 g/L) and at least one of the following two conditions exist:
Admission hemoglobin is < 10 g/L and at least one D&C† (endometrial sampling, office D&C endometrial fractional curettage, or vabra aspiration) has been performed for excessive menstrual bleeding
One D&C (endometrial sampling office D&C, endometrial fractional curettage, or vabra aspiration) has been performed for excessive menstrual bleeding and medical treatment has failed
Chronic pain characterized as severe, lasting ≥ 9 mo
If patient is ≤ 24 y, hysterectomy is indicated for:
Malignancy
Tubo-ovarian abscess

Hysterectomy Seemingly Contraindicated
Surgery is seemingly contraindicated if any of the following occurred:

Patient is < 24 y and patient does not have cervical cancer, endometrial cancer, ovarian cancer, or tubo-ovarian abscess
Cancer of cervix, stage II or higher
Cancer of endometrium, stage II or higher

*Case based: procedure is indicated, 100%; procedure is contraindicated, 0%; and population based: postoperative and pathology report diagnoses match, 100%.

†D&C indicates dilation and curettage.



External civilian peer review monthly cycle

itary hospital's identifying, through a computer-assisted sampling program, the patient records to be reviewed, for example, 20% of all primary cesarean sections (Table 2). The hospital medical records of all inpatients discharged three months earlier (ie, records sampled in June are those of patients discharged in March) are eligible for sampling. The sampling of a given diagnostic code is based on a digit sampling of the patient's social security number, a specified data set for all patients in military hospitals. The time lag allows an optimal period for completion of the hospital discharge summary and organization of the record according to military and Joint Commission on Accreditation of Healthcare Organizations standards.

Trained abstractors, generally registered record administrators, or accredited record technicians, visit the military hospitals on a regular basis

(monthly except for hospitals with an average daily inpatient census of fewer than ten, in which case the visit is quarterly) and abstract the sampled medical record data pertinent to the patient specific diagnosis or procedure under review. The abstractors' reliability is routinely measured for interrater reliability, which on average is greater than 98%.

Abstracted data are entered into a microcomputer on-site, then mailed on floppy disks or tape cassettes to a central computer for processing. The computerized abstracted data are then compared with computer algorithms created from the medical standards and criteria.

Cases meeting the review criteria are presumed to be acceptable. Those cases failing the review criteria are subject to further review by the physician peer review panel. Cases that suggest potentially serious care deficiencies but need

Table 4. — Cholecystectomy Standards*

Surgery is assumed to be indicated if the medical record shows any of the following:
Cholecystitis or cholelithiasis
Indicated by any one of the following symptoms on history:
Right upper-quadrant abdominal pain
Nausea
Vomiting
Flatulence
Chills
Fever
Fatty-food intolerance
By either of the following physical signs or laboratory findings (unless the cholecystectomy was elective):
Tenderness in right upper quadrant (epigastric) on physical examination
Temperature $\geq 38.3^{\circ}\text{C}$
Gallstones confirmed by one of the following:
Nonvisualization of the gallbladder on preadmission or preoperative intravenous cholangiography or oral cholecystogram or hepato-iminodiacetic acid scan
Stone(s) or sludge on preadmission or preoperative ultrasound/sonogram
Cholelithiasis as defined by:
History or presence of jaundice and symptoms, roentgenographic findings, and physical signs/laboratory findings (unless the cholecystectomy was elective) as defined previously
Cancer of gallbladder (described in pathology report)

*Case based: procedure is indicated, 100%.

extensive clinical review of the patient's chart and consultation with the military hospital staff trigger an on-site visit by a civilian physician specialist. Physician panel members and physician on-site reviewers are of a specialty appropriate to the case(s) under review. Those cases missing essential data necessary for the assessment of care are deferred for review pending the abstractor's retrieval of the missing data at a subsequent hospital visit. Cases that by themselves do not reflect a significant deficiency in care but warrant monitoring for a potential questionable medical practice pattern are identified for a future trends analysis that is planned for late 1988.

Any case judged preliminarily by the medical review panels as either a minor or major deviation from stated standards and criteria is referred to the military hospital that provided the care. Comments from the military hospital staff review are considered further by the medical review panel before a final judgment is made.

A flow diagram of these specific process elements is provided in the Figure. The monthly report of each hospital's experience is received by the military hospitals. Each medical command receives a report of all hospitals under its jurisdiction. At the hospital, this information is incorporated into the ongoing physician peer review of the quality assurance program in the hospital. The medical commands use this same information for general oversight of the quality of care provided by the military hospitals.

An inherent characteristic of this review system is that all preliminary analyses are based on review of defined sets of data abstracted from medical records, which are compared against explicit patient care criteria and standards. The limitations in using abstracted data are recognized and considered at all stages of review. Final determinations and reports involving individual cases alleged to be in noncompliance with the standards and criteria are made by practicing physicians and, where deemed necessary, are based on the complete chart review at the hospital. The review system process provides for the reabstracting of those medical records associated with cases that the physician review panel evaluates as potentially in noncompliance with standards or in need of a site visit. This limits the number of cases that otherwise might have been misevaluated due to errors in the initial abstraction of data or the absence of specific clinical information at the time of initial abstraction.

RESULTS

The original design of this activity focused on the review of individual cases. Analysis of aggregate cases, for example, all those cases sampled in a given month or a given hospital, was not the primary emphasis and the database management capacities of the program did not facilitate this analysis. Estimates of the aggregate results have been made, however, and the Department of Defense believes these esti-

mates reasonably reflect the overall results in sufficient detail for programmatic adjustments and collective quality of care improvements.

The medical records sampled and abstracted represent approximately 7% to 8% of the total hospital discharges. Approximately 15% to 20% of those cases sampled and abstracted fail the computerized screening and are referred to the peer review panel. Of these, approximately 75% are judged by the peer review panel to comply with the standards of practice as specified. These represent, therefore, "false-positives" from the initial screening. This leaves about 4% of the total cases tentatively not complying with the standards established. The subsequent review by the military hospitals and further consideration of this information by the peer review panel results in another 75% reduction in the cases judged to be in compliance with the specified standards. Therefore, less than 1% of the overall sampled cases are in noncompliance with stated standards.

A review of cases that contribute preponderantly to this rate provides additional insight. Of the cases reviewed during the period March 1986 through October 1986, five clinical review categories had four or more cases that, on final review of all abstracted information and subsequent military hospital comments, were judged as in noncompliance with specified standards. The highest rate of noncompliance (ten [11.6%] of 86 sampled) was for diabetic ketoacidosis. Among these the most frequent deficiency was the failure to document blood pH within 24 hours before discharge. The most frequent noncompliance event was hysterectomy (25 [1.7%] of 1432 sampled). By far the most common deficiency in these cases was the failure to perform a preoperative sampling of the endometrium. Because of the considerable debate generated by the military obstetrics and gynecology community regarding the appropriateness of this criterion, a consultative meeting of the leading military gynecologists with civilian counterparts identified by the American College of Obstet-

rics and Gynecology resulted in further criteria and specification. Cases of bony nonunion were the next most frequent noncompliance set (five [1.7%] of 282 sampled). No single factor explains the diversity of failures to meet the standards for this diagnosis. Four (0.9%) of 462 of the cases of ruptured appendix sampled failed to meet the standards and four (0.4%) of 891 of the cases of myocardial infarction failed to meet the standards.

COMMENT

The Department of Defense initiated a medical care peer review program to demonstrate the quality of care defined by selected medical and surgical cases. Rejecting more traditional preponderantly subjective medical records review and recognizing the paucity of generally accepted criteria in the medical literature, the Department of Defense program has created system-wide, objectively stated medical care criteria and standards with the assistance of nine civilian US medical specialty groups. Again rejecting traditional methods of direct medical records review, the Department of Defense program has developed a capacity to abstract essential data for comparative analysis against the defined criteria and standards. Practicing physician peers are used to review all cases not meeting the defined criteria embodied in a computer program logic. These peers can request more data and make site visits if unusual circumstances or data present. Each hospital with a tentative and presumed failure to meet the established standard in a specific case has an opportunity for review and comment before the peer review panel makes a final disposition.

To date, several important lessons have emerged. Of primary importance, the quality of care among these selected cases, as measured by compliance with civilian physician specialty group-endorsed standards, appears high. Less than 1% of diagnoses reviewed to date by the external peer review group fail these criteria. To our knowledge no equivalent civilian sector program exists; thus, no comparisons can be made.

The process and feedback of quality of care information to the military hospital has contributed to the ongoing quality assurance peer review that had been established concurrently. Reports from military hospitals frequently attest to the corrective factors already taken to avoid the same errors. Groups of physicians, such as the gynecologists, have met to debate further the appropriateness of criteria and standards. The constant constraint of medical record coding errors, either from clerical mistakes or incomplete information on which to base the medical and surgical diagnoses and procedures codes, has been highlighted. This issue, combined with a tentatively planned utilization of diagnosis related groups for resource allocation decisions at the military hospitals, has led to a commitment for encoders and

related automated information equipment to help alleviate this problem. The program has also reconfirmed other medical records deficiencies that will be assessed by a Department of Defense medical records advisory group created for this purpose.

Because no other medical care system utilizes, as yet, this standardized review against medical care standards created by civilian professional society members, we are unable to compare our results with those of others. Patterns of care by providers or by hospitals over time have not yet been analyzed because of data processing constraints. A new contract beginning in October 1987 and essentially sustaining the original concepts of the first contract will address these analytical challenges of assessing medical care by providers over time.

Assessing Quality

As concerns about the quality of medical care have increased, efforts to assess the quality of medical care have expanded significantly.¹³ In response to questions about the quality of military medical care, the Department of Defense has established an innovative system to evaluate and improve the quality of care provided to Department of Defense beneficiaries.¹⁴ The Department of Defense system is particularly noteworthy because it illustrates the likely direction for evolution in quality assessment systems. The strengths and potential weaknesses of the Department of Defense system deserve the close attention of the profession.

The Department of Defense uses a panel of civilian physicians to establish review criteria for selected diagnoses and procedures. These criteria are then incorporated into computer algorithms. A sample of cases is randomly selected from each of the selected diagnoses and procedures, and the medical records for these cases are abstracted and placed on computer databases. The computer algorithms are used to identify cases that appear to fail to meet the established criteria. The abstracts of these cases are subsequently reviewed by a second physician panel that determines whether a lapse in quality has indeed occurred. Cases with significant quality deficiencies are referred for further action by the hospital quality assurance programs and the military commands.

The Department of Defense deserves credit for establishing this system of assessing the quality of medical care. They have shown that objective review criteria can be established, that computers can be used effectively to assist quality assessment efforts, and that review of case abstracts can substitute for medical record review. The approach used by the Department of Defense is likely to diffuse throughout the medical care system because it has the potential to facilitate peer review that is more objective and cost-effective.

Nevertheless, the Department of Defense system, which is still under development, can be strengthened in several areas. As currently constituted, the review criteria address indications for ten surgical procedures and the processes of management for ten diagnoses. The Department of Defense system could be strengthened by expanding the scope of the review criteria, the number of procedures and diagnoses covered, and the percentage of cases evaluated.

The system assumes that the quality of care is appropriate if a case passes the review criteria. Consideration should be given to validating the appropriateness of the review criteria and the reliability of the process of reviewing case abstracts by having panels of physicians routinely examine the medical records of a sample of the cases that pass the review criteria.^{8,7} The Department of Defense system is effective in identifying *false-positives*—cases in which a lapse in quality may be incorrectly identified. The system is not, however, equally effective at identifying *false-negatives*—cases in which a lapse in quality has occurred but is not “flagged” by the review criteria. As a result, the Department of Defense assumption that compliance with civilian standards of care is high because less than 1% of cases fail to meet established review criteria should be accepted with caution.

Consideration might be given to use of statistical information and computer data regarding patterns of care and outcomes to identify other cases for review.⁸ Attention might also be given to ensuring that a consistent approach to addressing lapses in quality is followed.⁹

Computerized review systems have the potential advantages of objectivity and cost-effectiveness. But, at the current level of development, these systems are not fully able to adjust for patient variability or to assess the complexities in diagnosis and treatment.¹⁰ Current systems have been generally unsuccessful in providing meaningful comparison among institutions.^{11,12} Computerized review systems are also subject to omissions and errors in the process of abstracting medical records.^{13,14} Subjective peer review remains a central component of quality assessment. As a result, current computerized review techniques remain more effective as screening tools than as exact measures of quality.

As the review methods often determine the review results, ideally, a comprehensive quality assessment system should use multiple approaches for evaluating the quality of care.^{15,16} In my judgment, successful quality assessment systems will rely increasingly on explicit review criteria, computerized review of medical records, and statistical analysis of patterns of care in addition to traditional subjective peer review. Moreover, to be truly effective in improving the quality of care, quality assessment systems will be linked directly to effective quality assurance programs.

John T. Kelly, MD, PhD
American Medical Association
Chicago

CREDENTIALS

Dr. MAYER. Thank you.

Our system emphasizes continuous monitoring of quality and continuous monitoring of the credentials of the health provider. We have established very close relationships with the State boards of medical examiners, and we have also developed a structured relationship with the new national practitioner data bank.

PEACETIME HEALTH CARE

Even though our primary mission is wartime medical support, the peacetime health care that we deliver both to the 2 million men and women in uniform and more than 7 million others who are entitled to our care, is absolutely critical to morale, to recruitment, to retention, to the confidence of the soldier and his family if we have to go to war.

We provide that care in over 168 hospitals and more than 800 clinics. Care not provided in our system is purchased through the CHAMPUS Program, the Civilian Health and Medical Program of the Uniformed Services.

The medical staff needed in peacetime to provide for this huge population is necessarily somewhat different than the medical staff required to go to war. Even though in war we see very large numbers, in fact the majority of people who are disabled during war are not disabled by wounds, but are disabled by disease and nonbattle injuries. So we have a special need for surgical specialists in time of war.

But we have a different Armed Force today than we had 10, 15 years ago. Many of our fighting people are married. Many of them have children, far more than ever before. Even the Marines now have more dependents than there are Marines. Providing health care for these people requires tremendous numbers of skilled family practitioner specialists, as well as pediatricians, obstetricians, gynecologists, different specialties than are needed for war.

CHAMPUS

CHAMPUS provides about one-third of all hospital admissions of our beneficiaries, other than the uniformed force, and is responsible for about one-fourth of all the outpatient visits.

The costs of CHAMPUS have escalated extremely rapidly over the years so that we have made very intense efforts, using four different approaches, to try to encompass and control the costs of this massive program, which is really the biggest health program anywhere in the Free World.

First, we have started using some limited amounts of CHAMPUS money to invest back into our military hospital system to increase productivity and recapture patients from CHAMPUS. This is cheaper and safer and we need to keep our surgeons and internists and pediatricians in tiptop shape in case they are called upon to go to war.

Second, we have drastically reduced our reimbursements by modernizing our payments systems to one based mainly on the diagnosis related group prospective payment systems.

Third, we have started to institute throughout our system what is called today managed health care programs.

And fourth, we have vastly improved our ability to forecast CHAMPUS costs and to properly guide our payment methods.

Our CHAMPUS investments in the military hospital system include a partnership program whereby people can be brought in to give care to CHAMPUS patients, but the patients are kept in our hospital at great savings.

Second, it includes a health care finder program under which we find the care for the patient. This is opposed to the old days when we could not accommodate the patient because we did not have the bed or we did not have the specialist needed and the patient was told to find his own care under CHAMPUS. Now we make sure there is somebody who is fully qualified and properly credentialed who is able and willing to take the patient without any hassle, and we accomplish the referral.

We also have an alternative use of CHAMPUS funds program whereby we may use CHAMPUS funds to increase the use of the direct care system. An example would be improving an OB service so that we can deliver more babies, or improving a GYN service so we can take care of the increasing numbers of women in the Armed Forces.

Each of these programs—the partnership, the health care finder, and the alternate use of CHAMPUS funds to increase the military treatment capability—is beginning to pay off in very significant ways.

CHAMPUS PAYMENT REFORMS

Our payment reforms, I think, are particularly striking. Prior to 1987, CHAMPUS costs were increasing 25 percent per year. That was almost double the increase in costs in the rest of the civilian sector, and that in turn was double the cost-of-living increase.

From 1987 to 1988 and into this year, we reduced that rate of growth to 6 percent. During that same period, however, the private sector costs to the employer for health programs has increased 20 percent. In addition, the patients are paying a much higher premium under the Federal employees health plans and commercial plans than our people are having to pay.

Our payment reforms center around the use of diagnosis related groups, as I mentioned, and that alone will save CHAMPUS close to \$1 billion by 1991.

We have also applied a fixed per diem rate to reimbursement in psychiatric hospitals. Mental health care is one of the major costs in any health plan and it has been for us.

Alcohol and substance abuse programs are also being brought into the DRG system. Neonatal and children's care have been brought in or will be brought in next month.

And finally, we are limiting increases in reimbursements to individual physicians to something called the Medicare economic index, which should save us over \$160 million by fiscal year 1991.

MANAGED CARE DEMONSTRATIONS

Our managed care demonstrations are led by what we call CHAMPUS reform. The CHAMPUS reform initiative operates in California and Hawaii and is a fixed price contractual relationship with a very carefully evaluated health care provider. It is designed to provide better access to care, a lower copayment for the patient, and to save the Government about 10 percent of its CHAMPUS costs.

While it is too early to evaluate the program, since it has only been operating about 6 months, by a year from now we should have firm figures from the elaborate evaluation the Rand Corp. is doing to make sure that the program is functioning well.

We also have five so-called catchment area demonstration projects. All three services have at least one such project. For the catchment area demonstration, we will look at a 40-mile circle around a military hospital and from our CHAMPUS computers determine how much we spend on every CHAMPUS patient in that 40-mile area.

We will give the CHAMPUS money to the catchment area hospital commander, in addition to the money that he normally gets to run his hospital. He will have total responsibility for either providing care or obtaining the care in the civilian community by establishing relationships with the medical societies and with whatever available good medical resources exist in his community.

Those projects, which we first started talking about 6 or 7 years ago, are finally coming to fruition and will be in place later this year.

Third, there is a new fiscal intermediary preferred provider demonstration. We hired contractually from competitive bids major fiscal intermediaries in the six principal areas of the United States to pay the CHAMPUS bills. These intermediaries are people like Blue Cross/Blue Shield of South Carolina, Wisconsin Physicians Service, Blue Cross of Washington and Alaska, and so on.

The fiscal intermediary demonstration gives the FI, as we call them, the authority to make arrangements with groups of physicians in their area to provide care for CHAMPUS patients at a moderately discounted rate. In turn, the patients are steered to those preferred provider organizations. We believe that this will save us at least \$4 or \$5 million a year.

All of these demonstrations will be evaluated in great detail, not only by my own staff, but also under contract by the Rand Corp.

CHAMPUS REFORM

We had some problems in the beginning of CHAMPUS reform in California and Hawaii, mainly in California. The problems were not with the design of the program. The patients are getting care in much larger numbers than we ever expected. People are signing up for the program.

They are getting preventive care that was never before funded. They are paying a very modest copayment of \$5 for outpatient visits, instead of 20 to 25 percent of the bill charge, which here in Washington, for example, can run as high as \$150 for an outpatient visit. The patients are very well pleased.

The hospital commanders are pleased. Everything was going well, we have been monitoring the contract minutely since it started. However, we discovered very early that the contractor's computer systems were not adequate to do the bill-paying task that they have to do.

So we came down very hard before renewing for the second 6 months of the project, insisted on an improved claims processing system which they have obtained by contracting with Electronic Data Systems.

We have eliminated potential financial risks to the U.S. Government that were apparent in the way the business was running, and we have encouraged them to take on new top management, which indeed they have done.

In addition, of course, the flow of information between patients, subcontractors, contractors, and our military hospitals is going to be very much improved. Of course, the intense oversight will continue.

CHAMPUS COST FORECASTING

One little point about CHAMPUS cost forecasting. Historically, the Department of Defense has either failed to forecast accurately or to fund adequately the costs of the rapidly escalating CHAMPUS Program. Because we are controlling the costs better and because our forecasting methods are much better, we showed a tremendous improvement in 1988, as well as in 1989. For the first time, at the end of 1988 we had no unpaid claims which had to carry over and be paid in 1989. Furthermore, we did not require a major supplemental, like we were requiring regularly, as you mentioned, Mr. Chairman, in your statement.

The managed care voluntary enrollment of our patients, which somewhat, but not totally, limits their freedom of choice, as well as payment mechanism improvements, helps to give us for the first time in the history of the CHAMPUS Program, some handle and control on what were simply runaway costs.

CHAMPUS COST SAVERS

The principal cost driver, however, in CHAMPUS has been increasing numbers of patients that could not be cared for in our direct hospital system and, therefore, had to be referred out. In order to change the direct care system, we are, as I said, using small amounts of CHAMPUS money, I think less than 2 percent actually, to reinvest or to invest in improved capabilities within our own hospitals, so that they can take on more of the patient load.

In addition, we have partnership arrangements with civilian physicians who can come into the hospital and deliver care to the patient at no cost to the patient and at greatly reduced cost to the CHAMPUS Program. Also, we are doing an increasing amount of contracting, both personal services contracting and, in a number of places, we have contracted for the whole emergency suite operation or for a family practice clinic. This has proven to be a real cost saver and greatly increases the satisfaction of the patients.

MEDICAL MANPOWER STANDARDS

We have, for the first time, developed firm medical manpower standards. Prior to this, each service determined its staffing standards for peacetime missions on a different basis. There were great inconsistencies in the way hospitals were staffed and in the way requirements were determined.

However, we expanded on a personnel management engineering project that has been going on in the Air Force for some time, and will be publishing an initial set of 39 standards later this fiscal year. We are well on our way to ensuring that a common standard for staffing exists at all military treatment facilities.

One of the things I am sure that the standards are going to illustrate is that there is a very serious need for several thousand additional registered nurses on active duty in the Armed Forces, perhaps as many as 5,000, to deliver care the way we today deliver modern health care.

DOD/VA SHARING

Finally, a word about sharing between the Department of Defense and the Department of Veterans Affairs. This was authorized several years ago in legislation passed by the Congress, and we have today nearly 2,000 sharing agreements made at the facility level between a VA hospital and a Department of Defense hospital.

All of the services have sharing agreements. For example, instead of buying a new CAT scan for a military hospital when the VA has a CAT scan down the street that is not fully utilized, a sharing arrangement enables us to use their CAT scan.

Some of the more dramatic examples have been the construction of a new VA hospital in Albuquerque right next door to Kirkland Air Force Base, which needed a new hospital. We were able to arrange with the Veterans Administration for the Air Force to staff and operate some excess capacity in their new hospital.

So there really is a joint enterprise, greatly enriched from the standpoint of medical talent, adequately meeting the needs of both of these Departments and saving the Air Force at least \$10 million.

We are designing and will construct a replacement hospital in Las Vegas, which is probably the highest health care cost area in the world. That hospital will serve both Nellis Air Force Base and the veterans population there.

We are considering also and are close to establishing an agreement which is proving to be of extreme importance to us. The Base Closure Commission recommendation to close Philadelphia Naval Hospital presents us with a significant problem about hospital care throughout the whole Delaware Valley region.

The VA is building a new hospital only a few miles from the Naval Hospital, and we are well into discussions with them on joint use of that facility, which will obviate the need for DOD to invest in building a whole new hospital in the Philadelphia area, which already has an abundance of hospital beds.

It is vital that we continue our sharing agreements with the Veterans Administration. I do not believe that anything beyond that is necessary or desirable, but I think that those sharing relationships are very good indeed.

I tried briefly to say that we have tremendously improved our medical readiness posture. Through the enormous efforts of the Surgeons General and the staffs in the military hospitals we have achieved a superb medical quality assurance program that is without parallel.

And finally, we have come to grips and are beginning to show real advancement, better than the civilian community, in controlling the costs of health care.

That, Mr. Chairman, concludes my statement. I would be very happy to answer Senator D'Amato's questions or any other that you have.

Senator INOUE. If you wish to submit those responses, we would appreciate that.

Senator STEVENS. Mr. Chairman, Senator D'Amato left specific questions and I ask that they be put in the record and submitted.

Senator INOUE. Without objection, so ordered.

[The statement follows:]

STATEMENT OF WILLIAM MAYER, M.D., ASSISTANT SECRETARY OF DEFENSE (HEALTH AFFAIRS)

Mr. Chairman and members of the subcommittee:

I am pleased to have this opportunity to appear before you to discuss the medical programs of the Department of Defense.

This year the Department's request approaches \$13 billion to support health care operations and personnel for the nation's military health care system. 2.2 million active duty members receive highest priority for care, consistent with our primary responsibility to meet the health care needs of our uniformed personnel during peace and war. Yet our total health care mandate extends far beyond that, to an eligible beneficiary population that includes some 7 million dependents of active duty, retirees and their dependents, and survivors.

This year I have good news to report to you. We have made substantial progress in curing the readiness problems that faced us so dramatically just 5 years ago. Similarly with quality, public confidence has been restored to military health care. And, we have wrestled with and won the battle against out-of-control costs in the CHAMPUS program.

Today I will briefly summarize the programs which keep military medicine pre-eminent in health care today, and discuss where I hope it will go in the future.

MEDICAL READINESS

Medical Readiness has been and will continue to be our highest priority. Since 1981 DoD has dramatically corrected both sides of the readiness equation: procurement of wartime medical equipment and critically needed wartime personnel. Deployable medical assets, known as DEPMEDS, had been neglected for years, seriously undermining our medical readiness stance. Today, 75 percent of the minimal requirements for deployable equipment is either on hand or on order. The equipment has been standardized, tested and readied for positioning in key areas of the world.

There are now more than 100 additional medical specialists in the most critically short wartime specialties in the active force, up by 11 percent since 1982. In the reserve component, the Department has seen a 57 percent growth in physicians and a 63 percent growth in nurses serving in the Ready Reserve since 1982.

In 1982, the Department lacked an integrated, strategic medical planning document. Last year, the first DoD Medical Readiness Strategic Plan was executed and today more than half of its 289 milestones have been completed. Mr. Chairman, as a nation we are no longer in a position of weakness medically in the event of war. We are proud of this fact, and grateful for the support of this Committee in the realization of these important objectives.

QUALITY ASSURANCE

As no Member of this Subcommittee can forget, the early 1980s were a period of turbulence for the military health care system, based on questions about the quality of military medicine. That is no longer the case.

Civilian External Peer Review of Military Medical Care has been ongoing since June, 1986. Fifty-one aspects of patient care are identified for review. Medical care criteria were developed under the auspices of our contractor with the assistance of national medical specialty societies and approved by DoD. Review of patient care that fails the automated screening criteria is conducted by a panel of civilian physicians, comprised of board-certified specialists with active medical licenses and hospital admitting privileges. National medical specialty society representatives are included in all panels. The External Peer Review Program is confirming that the quality of medical care in military hospitals is indeed high, even when measured by explicit criteria against high risk medical and surgical events. As an article in the November 11 edition of the *Journal of the American Medical Association* reported, fewer than one percent of all reviewed cases to date fail to meet the stated standards and criteria established by the external medical review panels.

An editorial in the *AMA Journal* observed that "The approach used by the Department of Defense is likely to diffuse throughout the (civilian) medical care system because it has the potential to facilitate peer review that is more objective and cost effective." Mr. Chairman, if there is no objection, I would like to submit this article and editorial from the *Journal of the American Medical Association* for inclusion in the record of this hearing.

We have recently published a new Directive on Medical Quality Assurance that requires the accreditation by the Joint Commission on Healthcare Organizations of all fixed hospitals of 25 or more beds by December 1991. It also calls for the continuous monitoring of quality and appropriateness of care, the review of malpractice data using the Risk Management process, and verification of credentials for licensed ancillary personnel.

We have also refined and strengthened the ongoing assessment of provider performance through the issuance of a revised Directive on credentials review and clinical privileging. The Directive provides guidance to commanders on specific actions to be taken when questions of provider misconduct arise. It also assures that there will be a dialogue between the Services and civil agencies such as State Licensure Boards through a structured relationship with the National Practitioner Data Bank. The DoD program was praised by the Inspector General of the Department of Health and Human Services in a recent inspection of Federal medical programs.

PEACETIME OPERATIONS

As I noted, the Department's ability to perform its primary wartime mission has been vastly improved by our medical readiness achievements. While we have no greater obligation than to care for our service people in time of war, we have a critically important peacetime mission as well. The day-to-day peacetime operation of 168 military treatment facilities and over 800 medical and dental clinics worldwide and the management of the \$2.6 billion Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) program require constant attention to strengthen management and control costs.

The medical staff needed to meet our peacetime health benefit responsibility is quite different from the medical force needed to meet our wartime obligation. Combat medicine is weighted more heavily toward surgical care, whereas peacetime health care consists more of treating common illnesses and routine procedures. Our determination to accomplish both of these missions much more effectively demanded that we explore new approaches.

Over the past few years, the Department has focused a considerable amount of energy on the peacetime mission. The complexity and magnitude of the problems which have plagued the CHAMPUS program—which accounts for over one-third of the total admissions and over one-fourth of the total outpatient visits provided through the Military Health Services System—required that we pursue innovative and varied approaches to CHAMPUS reform.

Our intense efforts are paying off.

Our strategy employs four approaches to management reform:

- (1) using CHAMPUS dollars as "investments" in the generally less costly direct care system;
- (2) drastically reducing our reimbursements to civilian providers through modernizing our payment mechanisms;
- (3) testing a variety of managed care health care programs to meet the unique health care needs of a military population; and
- (4) eliminating the turbulence in CHAMPUS funding by improving our forecasting and claims payment methods.

CHAMPUS INVESTMENTS IN THE DIRECT CARE SYSTEM

Our belief is that investment in military medical treatment facilities is the most significant long-term strategy to contain CHAMPUS costs. By improving the ability of military hospitals to provide care, we hope to affect the dramatic increase in patient care referrals from the direct care system to the generally more costly CHAMPUS program.

Our investment initiatives include the Military-Civilian Health Services Partnership Program, Health Care Finder Programs, and the Alternate Use of CHAMPUS Funds Test. Each of these allows the Services to use CHAMPUS funds to increase military treatment facility capability in a number of ways. Through the use of civilian providers, paid discounted rates, to treat CHAMPUS patients in the military hospital, hospital capability and productivity can be increased. Such programs also use CHAMPUS funds to augment military hospital staff, or to help patients find appropriate health care when it is not available in the military hospital or clinic.

PAYMENT REFORMS

Between September 1987 and December 1988, DoD promulgated five separate payment reforms which have dramatically curbed the rapid growth of CHAMPUS costs for care purchased from civilian providers. Prior to 1987, CHAMPUS costs were increasing 25 percent per year. From 1987 to 1988, we reduced that rate of growth to just 6 percent. During that same period, private sector employer costs for health care jumped nearly 20 percent.

Payment reforms center on the use of Diagnosis Related Groups (DRGs) to pay CHAMPUS inpatient hospital charges on the basis of a fixed, prospectively determined rate. This reform alone will save more than \$1 billion in CHAMPUS costs between now and fiscal year 1991. Mental health care, another major component of CHAMPUS costs, has also been brought under prospective payment through fixed per diem rates in psychiatric hospitals and units and DRGs in general hospitals. Incorporation of alcohol and substance abuse, neonatal care and children's hospitals under DRGs this fiscal year means that virtually all hospital care is under prospective payment. The government projects an additional \$211 million savings from these refinements through fiscal year 1991. We are also limiting increases in payments to individual providers by linking professional fee increases to the Medicare Economic Index to save over \$160 million by fiscal year 1991.

MANAGED CARE DEMONSTRATIONS

Three managed care initiatives are now underway: the CHAMPUS Reform Initiative, the Fiscal-Intermediary-Preferred Provider Organization demonstration, and Catchment Area Management demonstrations. Each is being conducted to save money and improve access to services, especially when military treatment facilities cannot meet the full demand for primary health care posed by dependents and retirees. Each program induces beneficiaries to use a preferred network of high quality, cost effective health care providers rather than the more costly, traditional CHAMPUS program.

The CHAMPUS Reform Initiative, well known to this Subcommittee, operates under a fixed-price contract in California and Hawaii. In addition to better access to care for DoD beneficiaries in these States, we estimate the CHAMPUS Reform Initiative will cost 10 percent less than CHAMPUS would otherwise cost. Five Catchment Area Management projects now in planning stages will make CHAMPUS funds available to hospital commanders responsible for management of all health care needs of a catchment area population. A new Fiscal Intermediary Preferred Provider Organization Project, under which our CHAMPUS Fiscal Intermediary also manages a Preferred Provider option for DoD beneficiaries, is operating in Florida and Georgia, where it is expected to save at least \$4 million annually.

All three of these managed care demonstrations are subjects of very thorough evaluations being conducted for DoD by the RAND Corporation. As experience is gained from these and other health care demonstrations, we will construct a composite managed care model which will employ the most advantageous features of each for the military beneficiary population.

CHAMPUS REFORM INITIATIVE

The CHAMPUS Reform Initiative demonstration, now operating in California and Hawaii, is so far proceeding in a reasonable way. Managed care for our beneficiaries in those states is working. Beneficiary satisfaction is high. However, operationally our contract with the Foundation Health Corporation has had some problems. For-

tunately, our monitoring of this important project identified these deficiencies early, and we have taken strong steps to correct them.

It is not unusual in a change of fiscal intermediaries to experience problems in claims processing. In the case of the CHAMPUS Reform Initiative, we were presented with serious difficulties, including significant delays in payment of claims to participating providers. These problems were so serious that I considered not exercising the contract option period which began February 1. However, significant progress was achieved during January toward resolution of all outstanding issues. An alternate claims processing capability has been purchased by the contractor, potential financial risks to the government are being limited, and several new senior managers with significant government contracting and business management experience have been added to the Foundation Health Corporation team.

I believe that the identified operational problems have been adequately addressed by Foundation Health Corporation. An enhanced flow of information among the contractor, subcontractors and MTF commanders will produce faster results in correcting program deficiencies. Our intense oversight will continue to assure sufficient improvement into the Spring to warrant going ahead with this important health care initiative. At the Department's request, the RAND Corporation has recently prepared an initial evaluation report. It reports a continuing development through this "shakedown" period and the caution that "it would be premature and even irresponsible to assess CRI's effectiveness" at this point in the demonstration. This supports my belief that a year from now, its total accomplishments can be better assessed.

CHAMPUS FORECASTING AND FUNDING

Historically, the Department's inability to accurately budget for CHAMPUS costs had resulted in severe turbulence in CHAMPUS claims processing and payments, not to mention frequent requirements for supplemental appropriations from this Subcommittee. DoD mounted an aggressive effort to improve forecasting of CHAMPUS costs through better definition of cost components, and refinements in our forecasting methodologies. The result is a big improvement in fiscal year 1989.

A third of the way through this fiscal year, CHAMPUS spending is on track with our projections. After the turbulence experienced between fiscal year 1985 and 1987, sufficient funds were available to pay all claims processed in fiscal year 1988, no unpaid claims were carried over into fiscal year 1989, and no mid-year supplemental appropriation was required.

Admittedly, we have been concentrating the bulk of our reform efforts on controlling CHAMPUS and its previously spiralling cost escalation. These reforms have proved successful. Managed care is now a part of the Military Health Services System landscape. Voluntary enrollment in California and Hawaii has taken hold. By the end of 1989, one out of every three eligible CHAMPUS beneficiaries—2 million people—will have managed care options available for their use.

Additionally, programs are in place to enhance the capability of military treatment facilities to provide more care in-house. This is ultimately the surest approach to reducing CHAMPUS costs, and is urgently needed. The overriding factor in rising CHAMPUS costs continues to be workload coming out of the direct care system. Statistics through fiscal year 1988 show a continued decrease in admissions (since 1985) outpatient visits (since 1983) and operating beds at military treatment facilities and a continuing growth in the patient admissions and visits purchased in the civilian sector using CHAMPUS funds.

EFFECTING CHANGE IN THE DIRECT CARE SYSTEM

We have provided some new flexibility to hospital commanders to use CHAMPUS dollars to enhance medical treatment facility capabilities. But clearly, we need to do more to improve the productivity of the direct care system and to do a better job of stewardship over health care resources.

DIAGNOSIS RELATED GROUPS AS A BASIS FOR RESOURCE ALLOCATION

The Defense Authorization Act of 1987 directed the Department to establish Diagnosis Related Groups (DRGs) as the primary basis for resource allocation to military treatment facilities. This Committee reaffirmed its strong support of this initiative in last year's report.

Execution of this task is a formidable challenge for the military health care system. Unlike civilian hospitals, military hospitals and clinics do not identify the cost of individual patient cases, nor do they produce a patient bill from which a

DRG weight based on cost can be derived. In addition, cost accounting differs among all three Services, and separate costs cannot be segregated for inpatient and outpatient care. Often hospital commanders must operate with handcuffs within various appropriations categories which limit the reallocation of resources from low to high resource intensive activities.

DRGs offer two principal benefits to the military health services system. First, an allocation system that is based on the intensity of patient care workload should improve productivity. Second, a DRG allocation system will automatically distribute available resources among MTFs more equitably. Once we are able to examine patient care mix in a reasonable way, those hospitals that put the most resources on high cost services and reduce unnecessary resources applied to low cost services will be rewarded accordingly.

My office is moving ahead with implementation of this program. We have developed a method of weighting inpatient and outpatient dispositions as a DRG-type resource allocation method. We began in October, 1988, by using this for allocation of resources in the supply cost category which represents approximately 30 to 35 percent of the MTF operations and maintenance budget. In the meantime, we have just awarded a contract to look retrospectively at MTF patient care admission patterns. In fiscal year 1989 we will award a contract to begin formal encoding and grouping of patients and treatments into DRG groups. The computer software to facilitate this at the MTF level should be proliferated in fiscal year 1990. Looking beyond 1990, the Composite Health Care System (CHCS) is expected to be integrated with the majority of DRG program features prior to its full implementation.

The application of DRGs to the military health care system is a very complex task, but one which holds promise for marked improvements in resource management and productivity of military hospitals and clinics. It should have great implications for the use of CHAMPUS resources as well, by permitting MTF commanders to know more precisely the costs of services, and to make deliberate choices about care that is provided in-house and that which it would be more economical to purchase from civilian providers.

JOINT HEALTH CARE MANPOWER STANDARDS

A recent report to this Committee by the Surveys and Investigations Staff found that adequate staffing of Military Treatment Facilities is a problem at many hospitals. As the Blue Ribbon Panel on Sizing DoD Military Treatment Facilities pointed out several years ago, each of the Services staffs its hospitals differently with respect to both total manpower and provider mix per unit of workload. Rather than staffing hospitals based on estimated and validated requirements, staffing of military health facilities is too often driven by manpower allocations. This makes it difficult to ensure that staffs are adequately sized.

To address this problem, Health Affairs launched a two-phased initiative to develop command manpower standards for all work centers in the Military Health Services System. Publication of the initial set of 39 standards will be later this fiscal year. We are well on our way to ensuring that a common standard for adequate staffing exists for all our military health facilities.

VA/DOD SHARING

The Congressionally authorized program for VA/DoD Resources Sharing has proven beneficial to military hospital commanders. In the future, VA/DOD Sharing projects will be subject to a new external monitoring system, and will be approved only if they comply with basic reimbursement guidelines and recurring reporting requirements. New review mechanisms will ensure quality, productivity and savings.

I want to take this opportunity to comment on recent calls for legislation to mandate joint administration of military hospitals and Veterans Administration facilities. While I recognize the resource problems now facing the VA, I could not endorse a proposal that would take two overburdened health care systems and effectively merge them. Such a move would so consume the administrative resources of both Departments as to cause deterioration of patient care and the management systems of each. I cannot permit anything to erode this Department's determination to fulfill its mission of medical readiness, protection of the military health benefit for all eligible DOD members and their families, and attention to cost and quality health care. It is vital that DoD and the VA continue resource sharing agreements where they prove helpful. But calls for legislation to force regional joint administration and to compel use of CHAMPUS funds to pay for care in VA facilities remove our beneficiaries' freedom of choice, threaten the ability of veterans to gain access

to VA facilities, and resemble a Trojan horse hiding a full scale merger of the military and Veterans medical systems.

This completes my statement. I will be pleased to answer questions at this time.

NEED FOR SUPPORT PERSONNEL

Senator INOUE. Before proceeding with my questions, I would like to make a short statement. Several days ago I had the great privilege of visiting with Major General Rumbaugh to discuss matters of concern to him. We spent time discussing the need for support personnel. He pointed out that physicians had to do clerical work, secretarial work, when they should have been providing professional services. He described the problems he had with the shortage of nurses.

He was also concerned with the proposed bonus schedule, which differentiates between the specialties, causing much dissension among the physicians. He spoke of the need for parking facilities, because without those, patients were unable to keep their schedules.

He was then in a paratrooper uniform, because a few hours later he proceeded off to Honduras.

I would just like to say that we will miss him and we would like to extend to his family our condolences. And if we can, we would like to promise him that he will get his parking space. [Applause.]

There is a question that I have never heard asked in any one of these hearings. We speak of readiness, we speak of the improvements we have made. Although we try to avoid discussing this, we must always be prepared for that awful possibility of warfare. What happens to dependents when war comes?

The beds are going to be filled. This is a long time ago and I suppose you cannot make an analogy, but when World War II came along the beds were so woefully inadequate in our area that we took over three high schools and converted these high schools into hospitals.

And what happens? Do we have a contingency program for dependents?

NATIONAL DISASTER MEDICAL SYSTEM

Dr. MAYER. We do not have it spelled out in detail by the numbers, a plan for exactly what happens to x number of dependent patients in Walter Reed or Bethesda or the other hospitals.

There is, however, a national disaster medical system, part of which is a joint effort of the Veterans Administration, which can supply us with 31,000 beds very quickly. This joint venture includes also the Federal Emergency Management Agency, our Department, and the Department of Health and Human Services and can provide approximately 100,000 beds.

The national disaster medical system has helped alleviate two major problems. One is how to rapidly expand the capability of our hospitals to receive wounded. The other is how to take care of the many patients who would be in our hospitals who might have to go out into the civilian community for care.

No one can predict exactly how many such beds would be needed, but of course we would deploy immediately many, if not

most, of our uniformed health services personnel to a theater of war. Our Reserves would move in very rapidly behind them to keep our great hospitals operating.

The national disaster medical system would be alerted and prepared to accept casualties. I have no doubt that in a major war there would be a real problem of where to put all the dependents and retired people who are currently being treated in our system.

One, probably the only, fortunate side effect of the fact that American industry has overbuilt hospitals is that there are a great many vacant hospital beds throughout this country, and we would expect to send our patients to them. In fact, in many hospitals they are running at 50- to 60-percent capacity.

But a war, any general war, is going to create a medical demand, in view of the way we deliver medical care today, that is absolutely unprecedented, as it would create unprecedented demands for food and ammunition.

Senator INOUE. I realize that it is not possible to predict precisely the outcome of any conflict, but we do have contingency plans for everything else. If you look through the Pentagon files, there are contingency plans for everything else.

I think it would be reassuring to the men and women in uniform if they knew that our leaders had some contingency plan in the event of a major conflict. So I would suggest that something be done in this area.

MEDICAL USER FEE

Mr. Secretary, in listening to the testimony of the four senior enlisted men, one of the matters of major concern, and it was often repeated by all of them, was the proposed user's fee.

Dr. MAYER. Yes.

Senator INOUE. The one that OMB is recommending, supposedly to cut down costs and cut down visitations. What is the official view of the administration? What is the view of the Department of Defense?

Dr. MAYER. Well, I am not sure how Secretary-designate Cheney will respond to the user fee proposal, but I can assure you that all of the Armed Forces, with a unanimity almost never seen in any other area, will express their resistance to the imposition of a user fee in military treatment facilities.

And as you know, there is essentially a user fee in CHAMPUS; that is, a copayment and a deductible that has to be paid.

The idea of a user fee is pretty nearly universal in the health care industry today, and as recently as 2 weeks ago the Health Minister in Egypt, where they have a totally socialized health system, said that they found it necessary to impose a small user fee in order to reduce utilization of the system.

There is a widespread belief, that I do not subscribe to, that our beneficiaries overuse the military health care system. I give you this by way of example. At Camp Lejeune, NC, which is a major Marine Corps training base, the average young mother coming to the hospital for help with her children is 17½ years old. Her husband is likely out in the field someplace, if not overseas.

Her mother and father are in Iowa or someplace, and here is this youngster herself with a baby—actually, statistically with 1.5 babies—who comes to the hospital, maybe in the middle of the night because the baby has been fretting and cranky and has a little fever, and after a couple of days it does not get better.

Finally, in the middle of the night she just cannot stand it any more and she comes to our hospital. Now, the baby may have something very minor, and it would be very easy to say retrospectively, that is overutilization of the health care system.

I say that is not overutilization of our health care system. We have a different responsibility to the families, let alone to the uniformed people, but to the families of our uniformed people.

We have a great many young people disrupted from and removed from their home communities, and even if at George Washington University or the University of Hawaii it might be overutilization, we want those patients to come in and see us.

They are part of our military family and they are entitled to use us, unsophisticated though their use of the system may be, whenever and wherever they think they need it.

So I personally do not think that the imposition of a user fee in a military hospital will have any beneficial effect whatever. I do not think that it will save substantial amounts of money. I realize that I am making a statement in opposition to people who from a financial management standpoint are much more skillful and experienced than I am.

But as a physician, as one who has spent more than 30 years in the uniform of this country, my personal belief is that a user fee will be detrimental, risky, may drive away some patients who ought to come in, and would be backing down from a solemn commitment of this country to the men and women and their families who serve it.

Senator INOUE. I like that answer.

I do not know if you have noticed, Doctor, but this subcommittee will be placing emphasis in different areas. Most people expect this subcommittee to be concerned primarily with big weapons systems.

Dr. MAYER. We are a big weapons system.

Senator INOUE. And we have had several hearings to date, and all we have touched upon are personnel. We will be spending much time on personnel matters, health care, quality of life.

I realize that when I was in the service about 5 percent of the men had dependents. Times have changed. I think it is about 60 percent today. And I also believe that when a young man or a young woman signs the dotted line, he or she has entered into a contract with the Government of the United States, and it may be difficult to live up to the terms of the contract.

But I think we are obligated. So I am glad you used the word "commitment." It may be an expensive one, but it need not necessarily be this or the other. I think we can have both readiness and quality of life.

Tell us your experience with the CHAMPUS reform initiative. I could ask you questions, but I think a detailed reply would be much more useful to us.

[The information follows:]

MARCH 1989

REPORT TO CONGRESS

CHAMPUS REFORM INITIATIVE DEMONSTRATION PROJECT

The First Six Months of Operation

August 1, 1988 - January 31, 1989

I. EXECUTIVE SUMMARY

Several years ago, it was apparent to anyone looking at the two components of care comprising the Military Health Services System (MHSS), that the rate of growth of The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) was substantially faster than the direct care system's. Department of Defense (DoD) efforts to improve CHAMPUS have been directed at three objectives: contain costs, enhance services and improve coordination.

Pursuit of these objectives has resulted in development of three broad management initiatives: First, a series of initiatives was implemented to restore CHAMPUS workload to the direct care system of military medical treatment facilities (MTFs). Second, a series of CHAMPUS payment reforms put in place prospective payment systems employing Diagnosis Related Groups (DRGs) and per diem payments for most hospital services and use of the Medicare Economic Index (MEI) to control increases in individual provider services. Finally, three broad based managed care demonstration projects were developed: the CHAMPUS Reform Initiative (CRI), the Catchment Area Management (CAM), and the Fiscal Intermediary - Preferred Provider Organization (FI-PPO).

The report deals with CRI, the demonstration project that has received the most attention. Congress provided specific demonstration authority for the project which is designed to improve CHAMPUS through competitive selection of a financially at-risk contractor to underwrite delivery of CHAMPUS health care services. Congress endorsed a three-year phase-in of CRI, starting with a one-year demonstration, to be followed, if successful, by nationwide implementation.

The Reform Initiative demonstration provides two new health care options for CHAMPUS beneficiaries: an Exclusive Provider Organization (EPO) plan called CHAMPUS Prime and a Preferred Provider Organization (PPO) plan called CHAMPUS Extra. To the beneficiaries, CHAMPUS Prime resembles a Health Maintenance Organization (HMO) since it requires enrollment and exclusive use of network providers for any CHAMPUS care in return for enhanced benefit coverage and limited cost-sharing. CHAMPUS Extra offers beneficiaries who do not enroll in CHAMPUS Prime the option of using the same network providers in return for decreased cost-sharing and no claims filing. The two new health care options are the principal elements of CRI which seek to achieve the three objectives of contained costs, enhanced services and improved coordination.

After a two-year development and procurement phase, DoD awarded the CRI contract February 1, 1988 to a consortium of companies led by Foundation Health Corporation (FHC) and including as subcontractors Foundation Health Plan, a subsidiary of FHC, Partners Health Plan, made up of Voluntary Hospitals of America and Aetna Life Insurance Company, Queens Health Care Plan of Hawaii and Blue Cross of Washington and Alaska. CRI services started on August 1, 1988 in California and Hawaii which hold 13% of the 6.2 million

beneficiaries eligible for care under CHAMPUS. The area accounts for 20% of annual CHAMPUS program costs, estimated at \$2.6 billion for Fiscal Year 1989.

In the last three years, the Department has submitted 10 reports to Congress on the cost, structure, evaluation methodology, and impact of this major demonstration. This report provides the first preliminary information on results of the demonstration. It covers evaluation of both the implementation phase (February-July 1988) and initial operational months of the CRI project, with particular emphasis on preliminary demonstration results during the period August 1, 1988 - January 31, 1989. A portion of this report was prepared by The RAND Corporation, which is performing the independent evaluation of CRI. Much of this report focuses on the performance of the CRI contractor; the RAND chapter focuses on the CRI demonstration program.

Initial results of CRI Implementation

From a DoD perspective, although there were some snags, the contractor fulfilled the charter to begin services to CHAMPUS beneficiaries on August 1, 1988. The Congressional parameters required that the demonstration project begin not later than September 30, 1988. Problems in establishing the CHAMPUS Prime and Extra health plans, the enrollment program, the provider networks, and CHAMPUS Service Centers at MTFs were not unusual in the context of setting up a managed care program of this scope and complexity.

Through the first six months of operation, approximately 25,000 beneficiaries enrolled in CHAMPUS Prime, about twice the number projected for that time period. As indexed by complaints, disenrollment and informal feedback (including media coverage) beneficiary satisfaction is high. Over 9,000 providers and 100 hospitals have signed discounted contracts under the managed care umbrella. All physicians are credentialed and approximately 80 percent are board certified in their respective specialties. Utilization management procedures are in place to assure that beneficiaries receive the appropriate amount of care at the most cost-effective level. Some providers from the mental health community have raised concerns regarding this element of the demonstration project.

Under the CRI, more than 100 "health care finder" medical personnel are available in 26 MTFs throughout the two-state area to assist beneficiaries and hospital personnel in locating the most appropriate sources of care. During the first six months of services the finder function has handled thousands of calls resulting in over 10,000 referrals to network providers and almost 600 referrals to MTFs.

Problems in the contractor's claims processing systems and management structure have presented significant difficulties, including severe delays in paying claims. The government seriously considered not exercising the contract option for the second six-month operation period, which began February 1, 1989. Foundation Health Corporation contracted with Electronic Data Systems Corporation (EDS), a subsidiary of General Motors, to resolve the claims processing problems. In view of this alternative claims processing capability, contractor management changes, and contract modifications to ensure greater protection of government funds, the six-month option period for February through July 1989 was exercised.

Initial Results of RAND Evaluation

Much information provided in the RAND Corporation portion of this report was obtained from an extensive series of interviews, primarily of MTF and contractor personnel. RAND observes that a key feature linking the contractor and MTFs was to be resource sharing. MTF personnel are disappointed that resource sharing did not get started during this period. However, despite the lack of resource sharing, many MTF commanders and administrators still portray themselves as enthusiastic partners in the demonstration.

The RAND evaluation also includes information from a beneficiary survey about familiarity with CRI and interest in the new program, and a military physician survey about anticipated effects on MTFs. Among respondents to the baseline survey, 51% of active duty dependents and 58% of retirees and their spouses reported they do not currently use CHAMPUS. Seventy percent of active duty dependents reported they rely on the MTFs for their health care and only 14% on civilian providers, with the remainder reporting they have no usual source of care. In contrast, 49% of the retired nonusers of CHAMPUS reported relying on civilian providers and 35% on the MTFs. Regardless of their usual source of care, almost all of the beneficiaries surveyed expressed potential interest in the new CHAMPUS health care options offered under the CRI demonstration.

RAND reported that initial interviews with MTF physicians revealed frequent misperceptions about the purpose and functioning of CRI, although the physicians' familiarity with the program seems to be increasing with experience. Many of the physicians seemed glad that the MHS was undergoing change. This optimism was generally combined with concern over the possibility that CRI might increase the demand for already scarce specialty staff, ancillary services, and administrative support.

Preliminary results from the RAND survey of almost 400 military physicians and other providers from the demonstration MTFs show that only 19% reported they knew nothing about CRI, but only 21% considered themselves well informed. Expectations regarding the effects military physicians thought CRI would have on their own MTFs indicated more providers generally expected a positive effect than a negative effect. Expectations were most positive regarding CHAMPUS beneficiaries' access to care and benefits and the expectation of many military physicians that CRI could relieve some of the pressure on MTF outpatient clinics.

Similar to DoD assessments, the RAND report observes that the CRI program began slowly, but that the pace has accelerated throughout the first six months of operation. RAND's preliminary information indicates the first six months of operation have been marked by continuing development of most programs, with unforeseen problems impeding full implementation of some. Most problems can be tied to deficiencies in claims processing. RAND believes, even with EDS now on-board, this problem and its effects on other CRI features will not disappear for at least another six months to a year.

RAND concludes that although some CRI features are still not implemented, progress has been notable and steady throughout the first six months of operation. RAND evaluators observe that it will be some time before the complex behavioral changes among beneficiaries and health care providers will develop and become apparent in the data. They believe, at this date, it would be premature and even irresponsible to assess CRI's effectiveness. RAND plans to provide a comprehensive assessment of CRI's effects in the fall of 1990.

Initial Cost Impact Estimates

While data are currently insufficient to make cost projections for the Initiative, early determinants suggest that many mechanisms to produce cost savings are in place. Again, the claims processing and management information system difficulties are hampering this process. The Department has directed an interim reporting system to determine the overall effects of CHAMPUS Prime and Extra on utilization and costs. This system will also produce the data needed to document the substantial discounts from the current CHAMPUS allowable rates which the contractor reports.

The Department plans to reassess the viability of the CRI demonstration project during the next three months. We expect this reassessment to produce firmer information on the resolution of claims processing deficiencies, actual data on program costs and intended savings for the first six month period of operation, further progress on the RAND evaluation, possible changes to

contractual provisions to encourage resource sharing arrangements and other valuable indicators of the results of CRI. We expect this reassessment to guide upcoming decisions on whether CRI should be continued, revised or terminated. We remain hopeful of positive findings. We plan to have this assessment completed, with a supplemental Report to Congress, within 90 days.

II. BACKGROUND

In the 1987 Defense Authorization, the Congress provided specific demonstration authority to conduct the CHAMPUS Reform Initiative (CRI) which is designed to improve CHAMPUS through competitive selection of a financially at-risk contractor to underwrite delivery of CHAMPUS health care services. In the 1987 Defense Authorization Act, Congress endorsed a three-year phase-in of CRI, starting with a one-year demonstration, to be followed, if successful, by nationwide implementation.

Congressional Requirements

Three key parameters were set by the 1987 Defense Authorization Act:

1. The demonstration project was to begin not later than September 30, 1988. Actual delivery of services began on August 1, 1988.
2. The scope of the demonstration was restricted to not more than one-third of covered beneficiaries. California and Hawaii, the CRI area, have approximately 865,000 beneficiaries, or 13% of the 6.2 million total CHAMPUS beneficiary population.
3. A health care enrollment system was to be implemented under the demonstration. The heart of CRI is a new CHAMPUS Prime health care option which requires enrollment. Contractor reports show that CHAMPUS Prime enrollment had reached over 25,000 individuals by January 1989. This is more than double the original target for the first six months of activity.

The Secretary of Defense was instructed to provide a series of reports to Congress on the CRI demonstration project. These reporting requirements were to provide information to determine CRI's viability for phased implementation to other states in the CRI region (Arizona, Nevada and New Mexico), or the other CHAMPUS Fiscal Intermediary regions in the United States.

Previous Reports to Congress

Ten reports already have been submitted to Congress by the Secretary on development of the demonstration project:

- o The first report, submitted September 1986, presented an analysis of the likely impact of the demonstration project on the benefits and costs of the current CHAMPUS program.
- o The second, submitted November 1986, described the scope and structure of the demonstration, as well as the key features of the Reform Initiative design.
- o The third, submitted February 1987, supplemented information in the November 1986 Report to Congress on six issues: Enrollment, Utilization, the Health Care Finder, Management Information Systems, Diagnosis Related Groups, and Uniformed Services Treatment Facilities.
- o The fourth, submitted February 1987, described the methods the Department of Defense established to assure effective and fair competition among health care providers under the CHAMPUS Reform Initiative demonstration project.

o The fifth, submitted July 1987, discussed the Department of Defense plans to link the Congressionally mandated health care enrollment system to the phased implementation schedule of the CHAMPUS Reform Initiative.

o The sixth, submitted July 1987, described the RAND Corporation evaluation study plan for the demonstration project. At the request of Congress, the Department of Defense contracted with RAND to undertake an independent evaluation of the demonstration. The RAND evaluation study will describe the implementation of the CRI programs; evaluate the effectiveness of CRI in achieving its goals; estimate, where possible, the long-term effects of CRI on the Military Health Services System (MHSS); identify problems revealed by the demonstration project; and recommend changes in the program.

o The seventh, submitted September 1987, discussed the background and current status of the CRI demonstration, as well as unexpected business downturns in the health care industry, and the significant cost savings achieved through a collateral CHAMPUS reform, implementation of diagnosis related groups (DRGs).

o The eighth, submitted January 1988, provided a "WHITE PAPER" on the contract award under the CRI demonstration project, and announced the Department's position to operate the contract for at least one year prior to any decision on expansion of the program outside California and Hawaii.

o The ninth, submitted January 1989, further responds to the requirement to describe the Department of Defense plans for a health care enrollment system as part of the CRI demonstration, as well as the Catchment Area Management (CAM) and Fiscal Intermediary - Preferred Provider Organization (FI-PPO) managed care reform demonstrations now being conducted by the the Department.

o The tenth, submitted March 1989, further responds to the requirement to describe the structure and evaluation methodology of the CHAMPUS Reform Initiative, as well as a number of other demonstration projects the Department is conducting to reform the delivery and financing of peacetime health care services under the Military Health Services System (MHSS).

Purpose of this Report on CRI

This report responds to several requirements of the National Defense Authorization Acts and begins the first of a new series of reports to Congress on actual results of the CRI. Following this Introduction, Section III reviews the background and current status of various problems arising from deficiencies in claims processing experienced during the first sixth months of operation. Section IV includes the actual RAND Corporation report which describes the evaluation activities to date and summarizes available information on the progress of the demonstration.

Following that, because an understanding of the larger context of the demonstration is essential to forming a reasonable judgment about its potential viability as a continuing regional or national program, section V provides a brief comparison of the costs of providing health care under CHAMPUS with the preliminary costs of providing health care under the CHAMPUS Reform Initiative demonstration. Also included is a discussion of the lack of comprehensive cost and utilization, and risk sharing data needed to document actual program costs to the Department of Defense. Finally, Section VI concludes the Report.

This report is submitted pursuant to Section 702 of the National Defense Authorization Act for FY 1987, which directs the Secretary to submit reports on the status and results of the CHAMPUS Reform Initiative demonstration project and any changes the Secretary intends to make in the initiative during the proposed implementation.

III. CLAIMS PROCESSING DEFICIENCIES

During the first six months' of operations the CRI was impeded by serious claims processing deficiencies. Both Blue Cross of Washington and Alaska, the processor of standard CHAMPUS claims, and Foundation Health Corporation, the processor of claims from members of the managed care provider network, encountered major claims processing problems. Because of this breach of contractual standards for performance of the claims processing function, the Department issued two cure notices and withheld \$76 million in payments for several months.

Overview of the Problem

Typically, other civilian and federal sector large managed health care or CHAMPUS fiscal intermediary transitions experience start-up claims processing problems. However, because the CHAMPUS Reform Initiative is the largest managed care demonstration attempted to date in the United States, the claims processing delays had an adverse impact on the provider network, marketing, utilization review, quality assurance programs, contractor-subcontractor relations and contractor-government policy maker relations.

The deficiencies in claims processing resulted in a lack of data to determine the overall effects of the two new health care options for CHAMPUS beneficiaries - CHAMPUS Prime and Extra - on utilization and costs, and to substantiate the impact of large discounts the contractor reports within the CRI provider networks. In addition, problems encountered with the claims processing systems limited the marketing effort to CHAMPUS beneficiaries and the utilization review and quality assurance programs designed to monitor the quality and appropriateness of care provided through CHAMPUS Prime and Extra. The claims processing delays did not appear to impair delivery of services during the first six months of operation. A longer term assessment of the overall program impact is not possible at this phase of the demonstration.

Net claims receipts for the six months immediately prior to the first six months of CRI operations number almost 960,000. While this provides some historical perspective, the before and after CRI periods are not truly comparable for purposes of estimating expected claims receipts due to the claims submission lag factor. CHAMPUS accepts claims up to 24 months after the date of service making it difficult to estimate what an expected claims receipts volume should be for a new CHAMPUS fiscal intermediary, particularly one introducing a new program with an enhanced benefit package. The Office of CHAMPUS reports that, historically, 75% of claims received in a fiscal year are for services provided in that fiscal year. However, because of seasonal differences it would be dangerous to apply this annualized figure to a six-month initial CRI period. This makes forecasting claims receipts problematic.

All of these factors were given careful consideration in developing claims workload forecasts; however, the claims volatility of a large managed care demonstration like CRI can never be adequately predicted. For the first six months of CRI operations it was anticipated that approximately 70% of the total claims volume would come from the standard or the out-of-system claims area. Foundation Health Corporation subcontracted with Blue Cross of Washington and Alaska (BCWA) to process these claims. The remaining 30% of the anticipated claims volume generated from network providers would be processed by FHC.

Standard Claims Processing Problems

Four main problems contributed to BCWA's substandard performance during the first CRI operation period. First, actual receipts were higher than projected for standard claims. BCWA's original out-of-system claims projection was based on receiving 4,500 standard claims per day. By October, the daily workload was nearly 25% more than anticipated and averaged over 5,500 claims per day. Mid-way through the first six months period, additional claims processors were added by BCWA. Second, the demonstration required a provider recertification review that was new for BCWA. This process required certifying all providers used by the two outgoing fiscal intermediaries. Although BCWA began this project three months before August 1, 1988, the process took much longer than expected and provider claims payments were delayed pending completion of certification. Third, the CRI contract required development of new Health Care Service Records (HCSR). This requirement, unique to the demonstration, required a development effort which also caused delays in claims processing. BCWA's claims processing system had to be completely modified to report the HCSR data. And finally, the demonstration introduced new utilization review procedures to the standard CHAMPUS claims processing function to monitor the use of health care services for appropriateness. This program feature slowed claims processing to some degree. BCWA is proceeding cautiously in implementing this Reform feature.

After the government issued a cure notice in November 1988, BCWA made significant progress in December 1988 and January 1989. BCWA is now processing more than 5,800 standard CHAMPUS claims a day. This represents an increase of nearly 45% from the 4,000 a day being processed a few months ago. In addition, its claims backlog has been reduced more than 26%, and the inventory of claims over 21 days old has decreased from 43% to 34%.

BCWA was not in full compliance with contractual standards when the government exercised the second CRI operations option period on February 1, 1989. A key contract standard calls for 75% of all out-of-system claims to be processed within 21 working days of receipt. The government determined that BCWA claims processing delays resulted generally from a combination of the poor workload forecasting normally experienced in CHAMPUS transitions and unforeseen difficulties associated with continuing development of unique demonstration features. Foundation Health Corporation now reports that BCWA will achieve substantial compliance with standard CHAMPUS claims processing standards by 30 March 1989.

Network Claims Processing Problems

The other major area of claims processing problems occurring during the first six months' activities focuses on network claims. Like BCWA, Foundation also experienced a larger than planned claims workload. FHC's original in-system claims projection was based on receiving 2,400 network claims per day. Currently, the daily workload, like that experienced by BCWA, is almost 25% more than anticipated and currently averages 3,000 claims per day.

Although the FHC network claims processing delays parallel the poor forecasting and increased workload experienced by BCWA, there are no other major similarities between the problems encountered by the separate claims payment systems. The overriding in-system claims processing problem was the failure of senior FHC executives adequately to oversee and understand the grave implications of the claims processing difficulties.

Soon after health care operations began on August 1, 1988, the contractor started experiencing in-system claims processing problems. In fact, the managed care claims processing system the government paid for in CRI, known as "Eagle", never became fully operational as an automated claims processing function. For most of the first six months of the demonstration, only about one of every

four network claims was being processed. Many of these were being processed manually. For in-system claims the requirement is established in provider contracts, generally calling for a processing time of 30 days from receipt of the claim.

Despite several well-documented government site visits in September and October 1988, which identified this serious problem area, senior FHC management failed to recognize the major impact this problem would have on the demonstration. Equally important, they failed to respond adequately to the first cure notice issued by the government in late November 1988. A second cure notice issued in December 1988 resulted in senior management replacements clearly recognizing the importance of bringing contract performance into compliance and the inability of the Eagle system to support the network claims processing function.

In January 1989, the new senior management personnel at FHC decided to scrap the Eagle claims processing system. They selected Electronic Data Systems (EDS) as their new subcontractor for processing network claims. The four-year contract FHC negotiated with EDS calls for elimination of the network claims processing backlog by mid-June 1989. The RAND Corporation observes that, even if this plan is successful, the claims processing problem and "its effects on other CRI programs will not disappear for at least another six months to a year."

FHC is making interim progress to pay network claims faster as EDS develops a managed care claims payment system. Almost 1500 network claims a day are now being processed. This represents an increase of nearly 100% from the 750 a day being processed a few months ago. In addition, as a stop gap measure to ensure that providers remain in the network, the contractor has been making interim payments to providers. To date, interim payments worth more than \$30 million have been made to 90% of network providers. However, the total inventory and aged claims continue to require extensive attention.

Patient and Provider Complaints

As a result of payment delays the Department has received 86 letters from providers and a few beneficiaries expressing concern with the poor claims processing performance of FHC and BCWA in the CRI demonstration project. Only 3 of these letters concerned providers leaving the network and none were from beneficiaries disenrolling from the CHAMPUS Prime program.

An analysis of the correspondence shows that the vast majority of letters are from civilian psychologists providing CHAMPUS mental health services to our military families in the San Diego area. Their concerns have focused largely on the increased utilization review protocols that have been introduced under the CRI demonstration project. The utilization management program was developed using the expertise of nationally recognized civilian consultants, and reviewed by both DoD functional experts and the Rand Corporation personnel, who found the program employs standard methods.

The government has taken steps to address provider concerns. Government, contractor, and American Psychological Association representatives met in Washington, D.C. recently to discuss provider concerns with the CRI demonstration and other key issues. A second meeting, tentatively scheduled for mid-April 1989, is being planned in the greater San Diego area so government and contractor representatives can focus on the issue with local mental health professional groups represented. The Assistant Secretary of Defense for Health Affairs has formally communicated with various professional associations on this matter to outline the Department's specific plans regarding utilization management under the CRI project.

Changes Made To Resolve Problems

The government has agreed to the contractor's plan to improve the flow of CRI information through enhanced relationships with its subcontractors and medical treatment facility (MTF) commanders in the CRI test area. Monthly CEO level meetings with the subcontractors and quarterly meetings with MTF commanders should provide better communication and produce faster results in correcting claims processing and other program deficiencies.

Significant contract modifications were made prior to exercising the second operations option period of the demonstration to provide greater overall protection of government funds. Contract payments are now tied more closely to the contractor's performance and government dollars paid will be more closely aligned with the value of claims processed. Government funds will no longer be comingled with non-government funds and will be paid by FHC into segregated and restricted accounts at the health plan level. In addition, any interest on these funds which results from any contract non-compliance (i.e., delays in paying claims) will be credited to the government.

Next Steps

The government gave serious consideration to not exercising the second option period, which began February 1, 1989, because of the magnitude of the claims processing deficiencies. However, significant progress was achieved toward resolution of outstanding issues. As shown in Table 1 on the following page, a total of 67% of net claims received to date have been processed. Blue Cross of Washington and Alaska, which has received, by far, the bulk of the claims has processed almost 85% of their net claims receipts and continues to show rapid improvement. Foundation Health Corporation's performance has been less than acceptable, although they also show some improvement. Due to the scope and unique features of this demonstration program, FHC's failure to process claims faster is not totally surprising. In view of this, along with the senior management changes at the corporate level, the good delivery performance of the individual health plans, and the significant actions to ensure greater overall protection of government funds, the six-month option period for February through July 1989 was exercised.

Although the contractor received below average grades in management, cost accounting, and claims processing performance for the first six months of service under the demonstration project, the Department recognized the long-term evaluation of the CRI contractor, Foundation Health Corporation, must be measured against its ability to meet the major goal of health care cost containment and the broad managed care objectives for better access to primary care, strengthened quality of care standards and improved coordination between CHAMPUS and Medical Treatment Facilities.

As the next section of this report outlines, RAND Corporation believes "it will be some time before the complex behavioral changes among beneficiaries and health care providers (civilian and MTF) will develop and become apparent in the data." The RAND section of this report also reinforces that Department's belief that "it would be premature and even irresponsible to assess CRI's effectiveness" at this point in the demonstration project.

Table 1

CHAMPUS REFORM INITIATIVE - CALIFORNIA AND HAWAII

CLAIMS PROCESSING MONTHLY PERFORMANCE TREND AS OF: FEB 24, 1989

MONTH	***** FHC PERFORMANCE *****				***** BCMA PERFORMANCE *****			
	NET RECPTS	PROCESS	ENDING INVENT	% END INV OVER 30 DAYS OLD	NET RECPTS	PROCESS	ENDING INVENT	% END INV OVER 21 DAYS OLD
AUGUST 1988	6,456	21	6,435	UNK	18,501	906	23,764	UNK
SEPTEMBER 1988	19,140	1,385	24,190	UNK	25,536	17,215	32,085	UNK
OCTOBER 1988	29,246	5,027	48,175	UNK	82,513	45,011	69,387	UNK
NOVEMBER 1988	45,158	6,384	86,949	UNK	127,335	75,393	121,323	43%
DECEMBER 1988	41,636	19,566	109,019	UNK	80,015	100,798	100,540	41%
JANUARY 1989	63,406	30,804	112,920	UNK	109,453	119,212	90,781	35%
FEBRUARY 1989	54,343	24,658	172,106	UNK	76,049	76,314	90,516	29%

CONTRACT STD: 0% OVER 30 DAYS OLD

CONTRACT STD: 25% OR LESS OVER 21 DAYS OLD

EXPECTED FHC COMPLIANCE:

JUNE 15, 1989

EXPECTED BCMA COMPLIANCE:

MARCH 30, 1989

PERFORMANCE SUMMARY CONTRACT TO DATE	BOTH CONTRACTORS		** FHC SHARE **		** BCMA SHARE **	
	TOTAL	PCT	TOTAL	PCT	TOTAL	PCT
NET RECEIPTS	778,587	100%	259,385	33%	519,202	67%
CLAIMS PROCESSED	521,894	100%	87,045	17%	434,849	83%
PERCENT PROCESSED	67%	N/A	34%	N/A	84%	N/A

RAND EVALUATION

At the request of the Department of Defense, this section of this report was prepared to describe the RAND evaluation project's activities to date and summarize available information on the progress of the demonstration.¹ The focus of the RAND evaluation is on the CRI program, not the performance of the CRI contractor, although in many instances the two may be difficult to separate.

During the six months of the implementation planning and first six months of CRI operations, the evaluation project has focused on two major activities:

1. Conducting an extensive series of interviews, primarily of Military Treatment Facility (MTF) and contractor personnel, to document the pre-CRI situation in the demonstration area and monitor CRI implementation.

2. Collecting baseline data from a representative set of demonstration catchment areas and a matched set of catchment areas not involved in the CRI demonstration, including data from existing MHSS sources and surveys of beneficiaries and military physicians.

Most of the information contained in this report was obtained from the interviews and from the CRI contractors' reports. However, we also include some information both from the beneficiary survey about familiarity with CRI and interest in the new programs, and the military physician survey about anticipated effects on military hospitals and clinics.

In many respects, the CRI program began slowly, but the pace has accelerated throughout the first six months of operation. Many of those we interviewed suggested that the six-months implementation period for CRI was too short, and that nine to twelve months are needed for a large-scale program like CRI. Therefore, the first six months of operation have been marked by continuing development of most programs, with unforeseen problems impeding full implementation of some programs. However, although a longer planning period might have allowed the contractors to initially operate a more complete program and prevented some problems, an effort as complex as CRI was almost certain to require a "shake-down" period.

The New Health Options: CHAMPUS PRIME AND EXTRA

At the center of CRI are two new health care options for CHAMPUS beneficiaries: an exclusive Preferred Provider Organization (PPO) plan called CHAMPUS Prime and an optional PPO plan called CHAMPUS Extra. To the beneficiaries, CHAMPUS Prime resembles a Health Maintenance Organization (HMO) since it requires enrollment and exclusive use of a panel of health care providers in return for extensive coverage of health care services and limited cost-sharing. However, unlike many HMO's, CHAMPUS Prime does not reimburse these providers on a capitated basis.

CHAMPUS Extra offers beneficiaries who do not enroll in CHAMPUS Prime the option of using the same providers in return for decreased cost-sharing and no claims filing. This option can be exercised each time the beneficiary obtains health care, or he can use other providers under the standard CHAMPUS program.

The two options are designed to enhance health benefits while containing health care costs. The "preferred" providers--mostly hospitals and physicians--have contracted to treat CHAMPUS beneficiaries at discounted rates and to subject their treatment

¹ The study is being undertaken within the National Defense Research Institute, the federally funded research and development center sponsored by the Office of the Secretary of Defense at RAND.

decisions to utilization review. However, if the options attract beneficiaries who have been receiving health care through employer-provided health plans or other sources and encourage other beneficiaries to use more services, these cost containment features could be more than offset by increased utilization. It will be some time before we will receive the necessary data to determine the overall effects of CHAMPUS Prime and Extra on utilization and costs.

Implementing CHAMPUS Prime and Extra required that the contractors develop a provider network in all areas with CHAMPUS beneficiaries, market the options, enroll beneficiaries in CHAMPUS Prime, and conduct utilization review. Currently, these efforts are in varying stages of development.

Provider Network

In the near future, we will conduct a detailed investigation of the CRI provider network, including analyses of the characteristics of network providers, compared with other providers in the same areas, and the adequacy of the network in relation to the beneficiary population in each area. Our observations in this report are based on interview information.

Networks were in place in most areas by August 1, but since then the number of providers has increased by 48 percent, with most of the additions being made in September and October. Currently, the network includes 107 hospitals and 9,020 physicians and other practitioners. In most areas, the contractors now express themselves satisfied with the number, location, and quality of the providers they have recruited. However, they are continuing to work to augment the network in several areas where coverage is inadequate. The contractors also report that they generally received substantial discounts from the CHAMPUS allowable rates, but we do not have the data needed to document these discounts.

Marketing

The marketing effort was initiated in June, 1988 with a letter to all CHAMPUS beneficiaries in California and Hawaii. However, due to missing or out-of-date addresses, the consensus is that this letter did not reach many of these beneficiaries. To control costs, the contractors' subsequent marketing plans were targeted at CHAMPUS users to avoid attracting those who have been financing their civilian care in other ways or using the MTFs. For various reasons, including an inability to obtain historical data identifying CHAMPUS users, this market plan has been ineffective and is being replaced by a broader effort using military and local media. Nevertheless, problems encountered with the claims processing systems (discussed below) have continued to deprive the marketing effort of vital information on target audiences and marketing effectiveness.

Our baseline survey of beneficiaries included a question on familiarity with CRI. The survey was fielded beginning in June, 1988 but was not completed until October because of the need to correct and complete address information. Table 2 shows the proportion of respondents returning their questionnaires before and after the August 1st CRI start date who had some, only a little, or no familiarity with CRI. Overall, just under one-half of the respondents had at least heard of CRI, compared with only one-quarter of the respondents from outside the demonstration areas (not shown).

Table 2

BENEFICIARIES' FAMILIARITY WITH CRI

CRI Familiarity	Active Duty Spouses		Retirees and Spouses	
	Before August 1	After August 1	Before August 1	After August 1
Some familiarity	81	131	101	131
Little familiarity	29	31	46	39
No familiarity	64	57	44	48
Number of respondents	1704	883	2048	1160

In California and Hawaii, familiarity was greater among retirees and their spouses than among active duty spouses, with the rates for both groups not showing much change over time. Based on these data, the direct marketing of CRI and local press coverage of the demonstration appear to have made some beneficiaries aware of CRI, but a substantial number were still uninformed as of October.

After initial difficulties with computer support, the enrollment process for CHAMPUS Prime appears to have proceeded smoothly. With assistance sometimes provided by the health care finders or other enrollment personnel, beneficiaries have been able to complete the paperwork and select a primary care provider without undue difficulty.

Early Beneficiary Response

At this date, we have very little information on beneficiary responses to CRI. Contractor reports show that CHAMPUS Prime enrollment began to accelerate last fall and had reached 24,162 individuals by the end of January. This is more than double the original target for the first six months of 10,112 enrollees and represents four percent of the estimated population in the nine areas where the Prime option is offered. If, as expected, these enrollees are drawn primarily from those who rely on civilian providers and CHAMPUS for their health care, the true participation rate would in fact be much higher. Enrollment should continue to increase, especially since the number of areas covered by Prime will increase to 12 this month.

The response to the Extra option is more difficult to measure. In December, 34 percent of all claims received were from network or Partnership providers. We were told that approximately 17 percent of these were Partnership claims, but this figure is highly tentative. However, if we use the 17 percent, then we would estimate the Prime and Extra share of nonenrollees' civilian health care at about 28 percent. These penetration rates would appear to be respectable given the beneficiaries' general unfamiliarity with CRI and the newness of the program.²

Indeed, as we described above, high participation rates could result in increased costs if they reflect a shift to CHAMPUS from other sources of care. Among the respondents to the baseline survey, 51 percent of active duty spouses and 58 percent of retirees and their spouses reported that they do not currently use CHAMPUS.

² A forthcoming RAND study of five employer health plans with PPO options shows an average penetration rate of just under 50 percent (excluding HMO enrollee) after approximately two years.

Seventy percent of these active duty spouses rely on the MTFs for their health care and only 14 percent rely on civilian providers, with the remainder reporting they have no usual source of care. In contrast, 49 percent of the retired nonusers rely on civilian providers and 35 percent use the MTFs. Regardless of their usual source of care, almost all of these beneficiaries expressed potential interest in new CHAMPUS programs. Particularly if the estimated seven percent of active duty beneficiaries and 35 percent of retired beneficiaries who now finance civilian care in other ways are attracted to CRI, program costs to the Department of Defense could increase considerably.

IMPLEMENTATION OF OTHER CRI ELEMENTS

Health Care Finder

The health care finders at each military hospital (and many clinics) are intended to perform several functions: provide information about CRI, support the marketing effort, assist beneficiaries seeking to enroll in Prime, determine the availability of specialty appointments in the MTFs for Prime enrollees, refer both Prime enrollees and others to appropriate network providers, and facilitate the transfer of records between MTF and network providers. For the first several months, marketing and providing beneficiary information were the primary activities of health care finders because few beneficiaries had enrolled in CHAMPUS Prime or were sufficiently familiar with the program to request referrals. More recently, the volume of referrals and related activities has been rising. However, an assessment of the health care finder program would be premature at this time.

Utilization Review and Quality Assurance Programs

The CRI contract stipulates that the contractors develop a quality assurance program to monitor the quality of care provided through CHAMPUS Prime and Extra and a utilization review program to insure the appropriate use of expensive hospital and ambulatory services. We have interviewed the contractor personnel responsible for these programs and obtained operational manuals. Nevertheless, incomplete implementation limits our ability to evaluate both programs at this time.

When fully operational, the quality assurance program will include credentials review, identification of potential quality issues, hospital outcomes reporting, special studies, ambulatory records review, and reporting of grievances, fraud, and abuse. This program is in keeping with contractual requirements and employs standard methods. However, adequate claims processing and substantially more experience will be necessary before we will be able to conduct even a descriptive evaluation of quality assurance.

Due to the claims processing deficiencies, only the concurrent hospital review portion of utilization review is fully operational. Network physicians have been directed to request prior authorization of hospital admissions and for some other services, but there are no data on compliance rates. For both of these activities, reviewers are using regional length of stay statistics (for all payors, not just CHAMPUS). Although the subcontracting Plans target their lengths of stay at different percentiles (10th in Southern California and 40th in Northern California), in actuality these figures are rarely more than a day or two apart. All three Plans are developing extensive review methods for mental health services, the second largest category of CHAMPUS outlays after obstetrics. Finally, case management programs are planned but not yet fully staffed, and bill auditing currently is hampered by slow claims processing.

To avoid alienating network physicians who are encountering claims processing delays and, in some cases, are unused to having their care reviewed, the Plans are proceeding cautiously in implementing utilization review. Therefore, at least in the short run, discounts are expected to play a larger role in containing costs than utilization review.

Resource Sharing

Resource sharing, an important feature of CRI, has been derailed due to contractual provisions that render almost all arrangements unprofitable to the contractors. We understand that some changes may be made in the near future to correct this situation. Recently, the contractors have taken the initiative to develop a few limited resource sharing arrangements, primarily as a good-will gesture.

In the meantime, the Partnership program³ has emerged as an alternative method for augmenting MTF resources and relieving at least some of the resource shortages that are thought to cause inefficiency in delivering health care services. At first, Partnership agreements were negotiated between the MTFs and civilian physicians without the CRI contractors' involvement. However, new agreements are increasingly being made in consultation with the contractors.

Although the MTFs' experiences with Partnership physicians are still limited, there appear to be some lessons for the future implementation of resource sharing. First, the administrative burden on the MTFs of supporting Partnership physicians appears to have exceeded expectations. While some of the burden would be borne by the contractors under resource sharing, various activities such as negotiating agreements, arranging clinical space, modifying appointment and other procedures, and keeping records could still be expected to strain the MTFs' administrative capabilities. Second, the military physicians are concerned about the quality of civilian personnel brought in under either the Partnership program or resource sharing, and they are acutely aware of the higher earnings and more limited responsibilities of their civilian colleagues.

Finally, the ancillary departments in all the MTFs worry about their ability to support additional providers. Both resource sharing and Partnership agreements will have to provide at least some support resources for the additional physicians to be productive and to maintain the already inadequate support provided to military physicians.

Once the contractual provisions have been revised to accommodate resource sharing, this program may offer some advantages over the Partnership program. As mentioned above, some of the administrative burden may be shifted to the contractors. More important, resource sharing could provide some of the the acutely needed ancillary and nursing staff whereas Partnership is designed primarily to procure additional physicians (with or without their own support resources.)

Claims Processing

We have alluded to various problems arising from deficiencies in claims processing. Both Blue Cross of Washington and Alaska, the processor of standard CHAMPUS claims, and Foundation Health Corporation, the processor of network claims, encountered problems with claims processing. We have not investigated these problems in any depth. Information provided by the contractors shows that the

³ The Partnership program allows MTF commanders to contract with civilian physicians and certain other providers to provide health care to CHAMPUS beneficiaries in the MTFs. The providers are reimbursed by CHAMPUS at rates stipulated in the contract. Partnership agreements can only be negotiated with providers whose services are directly reimbursable by CHAMPUS.

backlog of standard claims is declining and should be eliminated in a few months. In contrast, only a fraction of network provider claims has been processed. Even if the current plan to switch to a subcontracted system is successful, this problem and its effects on other CRI programs will not disappear for at least another six months to a year.

CONTRACTOR-MTF RELATIONS

A key program linking the contractors and the MTFs was to be resource sharing. In its absence, there was much less motivation for the contractors and MTFs to work on developing the partnership, and MTF personnel are understandably disappointed not to be receiving the additional resources. However, despite the lack of resource sharing, many MTF commanders and administrators still portray themselves as enthusiastic partners in the demonstration. During our interviews, complaints from either MTF or contractor personnel about anything other than resource sharing are infrequent and often minor.

MTF commanders frequently express concern that, in the future, CRI will decrease the access to MTF care of military retirees who are Medicare beneficiaries. This could occur as the health care finders attempt to channel more CHAMPUS beneficiaries to the MTFs and if additional beneficiaries are attracted to the military system from other sources. Other issues may arise if the resource sharing program gets underway.

Military Physician Reactions

Our initial interviews with MTF physicians revealed frequent misperceptions about the purpose and functioning of CRI, although the physicians' familiarity with the program seems to be increasing with experience. Some physicians expressed regret that they had not been included in planning for the demonstration. Nevertheless, many of the physicians seemed glad that the MHSS was undergoing change. This optimism was generally combined with concern over the possibility that CRI might increase the demand for already scarce specialty staff, ancillary services, and administrative support.

This fall, we conducted a survey of all physicians and some other providers (e.g. physician's assistants and nurse practitioners) in the demonstration and control MTFs. Preliminary results from that survey support the interview information. Of the almost 400 providers from the demonstration MTFs, only 19 percent reported that they knew nothing about CRI but only 21 percent considered themselves well informed. One-half indicated that they did not receive sufficient information.

We asked the providers to indicate what effects they thought CRI would have on their own MTFs. A simple tabulation of the results is shown in Table 3. In general, 30-35 percent had no opinion. The areas for which expectations were most positive were CHAMPUS beneficiaries' access to care and benefits, which many expected to relieve some of the pressure on the MTFs' outpatient clinics. Expectations regarding negative effects were relatively constant across the items listed, with more providers generally expecting a positive effect than a negative effect.

NEXT STEPS

Although some CRI programs are still not fully implemented, progress has been notable and steady throughout the first six months of operation. It will be some time before the complex behavioral changes among beneficiaries and health care providers (civilian and MTF) will develop and become apparent in the data. At this date, it would be premature and even irresponsible to assess CRI's effectiveness.

Table 3

MTF PHYSICIANS' EXPECTATIONS ABOUT CRI EFFECTS ON THEIR FACILITY

	Positive Effect	No Effect	Negative Effect	Don't Know
Level of resources	211	301	141	331
Outpatient workload	33	24	14	28
Inpatient workload	18	34	17	31
Efficiency	20	33	13	33
Coordination w/civilian providers	25	28	10	36
Diversity of patients	13	40	16	31
Access to health care for CHAMPUS Beneficiaries	54	11	4	31
CHAMPUS benefit package	46	12	6	35
Quality of care for CHAMPUS beneficiaries	22	22	13	43

During the remainder of this calendar year, evaluation activities will include (1) an assessment of the network of Prime and Extra providers, (2) continuing collection and processing of pre-CRI and some post-CRI data, (3) analysis of the baseline beneficiary and provider surveys, (4) redesign of the survey instruments for follow-up, and (5) continued monitoring of CRI operations through interviews. The follow-up surveys will measure a number of health care outcomes under CRI, including:

- o Participation in CHAMPUS Prime and Extra,
- o Access to and continuity of care,
- o Self-reported use of military and civilian health care services,
- o Beneficiary satisfaction with care,
- o Referral patterns between the MTFs and civilian providers, and
- o MTF physicians' satisfaction with military practice.

Initially, we had planned to field these surveys one year from the CRI start date. However, due to the slower-than-expected implementation and anticipated problems in locating active duty families just after the summer rotation period, we currently expect to field the survey in early 1990. That is also the earliest date at which we expect to receive claims data from the first year of CRI operations. According to this schedule, we will be able to provide a preliminary, but comprehensive, assessment of CRI's effects in the fall of 1990. In the meantime, we will develop as much information as possible on the demonstration's progress.

IV. THE CRI PROGRAM COSTS

The CHAMPUS Reform Initiative was designed primarily as a public and private partnership to demonstrate an improved method to financially underwrite delivery of CHAMPUS services in California and Hawaii which account for 20% of the total CHAMPUS annual program costs. The demonstration underscores several key principles.

1. Departmental commitment to award a contract only if costs would be no greater than what CHAMPUS would cost without the CHAMPUS Reform Initiative demonstration project.

2. The intent of the Department to use this project as the model for establishing a new nationwide reimbursement contracting methodology for CHAMPUS, which traditionally has used an inefficient and outdated cost-per-claim payment methodology developed in the mid-1960's.

3. Consistent with the incentives underlying a fixed-price contract, a government and contractor agreement to a financial underwriting mechanism for the demonstration providing for price adjustments to the fixed-price for unexpected events of two types: first, a set of formula adjustments for unpredictable events; and second, a risk corridor.

Although pricing terms under the contract became very complicated during the course of contract negotiations, the DoD policy held constant to proceed with CRI only if it would cost no more than CHAMPUS without CRI. This policy was also adopted by Congress and enacted into law as part of the FY 88 and FY 89 Appropriations Acts.

Bid Price

At award, the government expected CHAMPUS costs in the region for the period 1 August 1988 - 31 January 1989 to be \$253 million absent the CRI demonstration. The contract for the demonstration project was awarded for \$237 million. Adding allocated implementation costs, the total was about \$240 million, which represented an approximately 5% savings from what CHAMPUS would have cost without CRI. This reduction results from FHC's cost projection that includes CRI unique program efficiencies such as negotiated provider discounts, utilization management, and expected resource sharing agreements. As outlined in sections III and IV of this Report, however, it will be some time before we will receive the data needed to fully document this savings.

Adjusted Bid Price

The CRI contract places the contractor at-risk for health care costs, non-performance, and administrative costs. However, to protect the contractor from the possible consequences of his inability to predict some occurrences with certainty, a set of formula adjustments for certain events was developed for this demonstration. These adjustment formulas deal fairly with unexpected events over which the contractor would have little or no control and which also would have occurred in the absence of the demonstration project. From a practical standpoint, the adjustment process was a far less expensive alternative for the Government than paying an inflated base price in order to protect the contractor from uncertainty.

Several broad formula adjustments are incorporated into the financial underwriting mechanisms of the Reform demonstration. These include: diagnosis related group updates, unit price increases, MTF workload and case-mix changes, utilization trends, changes in number of eligible beneficiaries, and non-performance adjustments. The government's cost projections contain assumptions regarding these factors. These assumptions are corrected through a retrospective adjustment to the fixed-price when actual values are known.

The initial application of this formula to events that occurred prior to CRI operations beginning on August 1, 1988 revised downward both our estimates of CHAMPUS costs without reform and the contractor's bid price. The revised estimate of CHAMPUS costs without reform became \$249 million and the corresponding change to the contract terms made the adjusted bid price become \$230 million (adding allocated implementation costs, the total was about \$233 million). The major factors that contributed to this reduced estimate and price were changes in price and utilization assumptions. The revised price when compared to the revised cost estimate of CHAMPUS without Reform preserves the 5% bid price savings target.

Actual Price

As previously stated, we do not currently have sufficient actual data to document the savings or non-savings in the first period because of FHC's and BCWA's substandard claims processing performance. At this point we cannot make even preliminary assessments of the amount of utilization, its costs or any probable net changes in utilization and costs.

We also do not yet have adequate national CHAMPUS and MTF data on which to base revised formula adjustment calculations and comparisons between CHAMPUS absent CRI and the CRI experience.

Risk-Corridor

The final adjustment mechanism to the CRI bid-price is application of a "risk corridor". This financial underwriting technique shares the financial gains or losses generally associated with unanticipated changes in utilization rates and users or, unexpected program savings associated with the demonstration, between the contractor and the government. The risk corridor terms could result in net savings or net additional costs in comparing CHAMPUS without CRI to the CRI experience.

To illustrate the operation of the risk corridor during the first year of operation, FHC bears full responsibility for the first 2% overrun above the adjusted bid-price and 30% of the next 18% of the overrun, subject to a stop-loss cap of \$5 million net equity. The adjusted bid price reflects a net \$16 million savings (after consideration of the allocated start-up costs) from the revised estimate of what CHAMPUS would have cost without CRI. Thus, at a point where the government's share under the corridor of any cost overrun would hit \$16 million, the government would break even. Any cost overrun above that point would mean a net government loss. If all factors that would impact the formula adjustments (i.e., events that would have happened anyway) are held constant, the break even point is approximately at a \$28 million cost overrun, which is nearly 15% over the adjusted health care bid price. This gives the government a cushion against any cost overrun that might occur.

At this point, we remain hopeful that when claims backlogs are eliminated and the information systems produce the critically needed data, the evidence will show that savings were achieved. Of particular relevance will be data pertaining to the long-standing issue of the net impact of savings attributable to managed care practices and provider discounts versus costs associated with the higher overhead for managed care activities and induced demand brought on by improved benefits.

We currently expect the program deficiencies in claims processing to be corrected so that the overall cost effects of the fixed price, formula adjustment modifications and risk corridor mechanism can be accurately identified by June 1, 1989. Because of this non-performance, the Department is still withholding \$12 million in payments for the first six months of operation. The government remains committed to the principle that the next option period will not be awarded unless it can be demonstrated that the

total contract cost, including adjustments based on most likely outcomes, are apparently no more than what CHAMPUS would have cost without the CRI demonstration project, thus assuring our continued compliance with the applicable statutory requirement.

V. CONCLUSIONS

Based on the foregoing discussion and analysis, the following conclusions are offered.

First, it appears the six-month implementation period for CRI was too short. However, although a longer implementation period might have allowed the contractors to initially operate a more complete program and prevented some problems, an effort as complex as CRI was almost certain to require a "shake-down" operational period.

Second, in many respects, the CRI demonstration began slowly, but the pace has accelerated throughout the first six months of operation. After initial difficulties with computer support, the enrollment process for CHAMPUS Prime appears to have proceeded smoothly. Through the first six months of operation, approximately 25,000 beneficiaries enrolled in CHAMPUS Prime, about twice the number projected for that time period.

Third, to address problems in the current CRI demonstration project, the contractor needs to adopt traditional management practices that have been successful in other government and private health care programs. These include a senior management strategy of establishing sound and well-communicated priorities for this large-scale, fixed price, managed care contract. The key priorities of the government are: a rapid and permanent solution to the claims processing and management information system deficiencies, a better system for coordinating activity between prime contractor and subcontractors, and an interim data reporting system that will document utilization, network discounts, and total program costs and/or savings.

Fourth, at this stage of the demonstration process, actual costs and benefits of the CRI health care optional plans, CHAMPUS Prime and Extra, cannot be fully determined. Costs and benefits will only be determined after FHC, BCWA, and EDS resolve outstanding claims processing and management information deficiencies. However, unless the contractor remains intensely committed to resolving these serious difficulties, Prime members and network providers may drop out of the program. A wave of dropouts could result in the project never achieving its objectives.

Fifth, CHAMPUS beneficiaries, MTF leadership, and military physicians remain positive about the effects of the CRI project, despite the significant delays in paying claims and the lack of resource sharing agreements. On the CHAMPUS provider side, the key concerns are the variety of utilization management techniques for controlling unnecessary or inappropriate services. This program is modeled after private and public efforts to control utilization without impeding access to needed care or reducing quality of care. The majority of concerns raised in this area have surfaced from mental health providers.

Sixth, the RAND Corporation's evaluators believe, at this date, it would be premature and even irresponsible to assess CRI's effectiveness. According to their current evaluation schedule, they will be able to provide a preliminary, but comprehensive, assessment of CRI effects in the fall of 1990. This report would provide the information needed by the Congress and Department of Defense to determine CRI's viability as a continuing regional or national program.

Seventh, the Department of Defense is committed to a fair and full test of the CRI demonstration project. This commitment only will continue as long as the two essential principles that have formed the cornerstone of this demonstration remain apparent and

documentable. The first principle is that the demonstration should continue if the actual price is likely to remain below what CHAMPUS would have cost without the Reform Initiative. This principle is consistent with a key requirement Congress has enacted into law. The second principle is that, regardless of potential contract modifications and complex financial underwriting techniques, the total cost of the demonstration project, taken as a whole, must assure the right contractor incentives for strong and sound management practices.

And finally, the Department is currently reassessing FHC performance in meeting the two essential principles of the CRI demonstration project and whether actual results indicate that CRI should be continued, revised or terminated. We plan to have this assessment completed, with a supplemental Report to Congress, within 90 days. The Report will be submitted not later than 60 days before the government has to decide on the next option period under the CRI project, August 1, 1989. We remain hopeful that results will show net positive effects of this dynamic reform initiative.

REPORT TO CONGRESS
DoD HEALTH CARE DEMONSTRATIONS --
IMPLEMENTATION PROGRESS AND EVALUATION PLANS

FEBRUARY 1989

I. EXECUTIVE SUMMARY

In recent years, both Congress and DoD have focused substantial attention on reforming the delivery and financing of health care services under the Military Health Services System (MHSS), with particular emphasis on the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). From this attention there have emerged three primary reform thrusts: improvement of CHAMPUS payment methodologies to reduce costs; implementation of new programs to restore health care services in military medical facilities; and demonstration of alternative managed care strategies for CHAMPUS.

On the payment reform front, five separate final regulations were promulgated during the period September 1987 - December 1988, putting into effect new payment methods covering virtually the full range of health services under CHAMPUS. In addition, a companion peer review organization (PRO) program of quality and utilization review is being phased in during FY-1989. As a preliminary indication of the dramatic impact of these efforts, the rate of growth of CHAMPUS costs has been cut significantly, from an average annual increase of 25% for the two years preceeding payment reform (FY1985-87), to 6% for the two years immediately following implementation. The impact is expected to be similarly striking in FY-90.

A second reform thrust features efforts to use CHAMPUS funds to restore health care services in military facilities. Under the rubric "Project Restore", these include over 400 agreements to date under the Partnership Program, which allows CHAMPUS-paid civilian physicians to provide services in military facilities, and a series of FY-89 projects under the Alternate Use Test, which allows each Service to spend up to \$50 million of their CHAMPUS budgets for cost-effective initiatives to enhance military facility capabilities.

The third major reform focus is a set of managed care demonstration projects, the primary subject of this report. Following substantial Congressional guidance, DoD is proceeding to test three alternate models of managed care initiatives. These are:

- o An at-risk contract management model -- the CHAMPUS Reform Initiative (CRI) -- in which managed care activities are coupled with substantial benefits improvements under large contracts that place the contractor financially at risk. The project is in place in California and Hawaii.

- o A decentralized military management model -- the Catchment Area Management (CAM) project -- in which local military hospital commanders are made responsible for implementing managed care activities for CHAMPUS in the hospital's catchment area. Five project sites are now in various stages of planning.

o A fiscal intermediary enhanced management model -- the Fiscal Intermediary Preferred Provider Organization (FI-PPO) project -- in which CHAMPUS Fiscal Intermediary contracts are enhanced with new managed care responsibilities. This project is operating in Florida and Georgia, with a second site anticipated in FY-89.

All three of these managed care demonstrations are subjects of very thorough evaluations being conducted for DoD by The RAND Corporation. DoD anticipates that as experience is gained and lessons learned, there will emerge a composite managed care model, pulling from each project its most advantageous features.

In addition to these three major managed care demonstration projects, DoD is conducting a large number of other demonstrations. These include three previously operating activities made part of the 1987 "Kyl Amendment" on demonstrations: the Fort Drum project, the Tidewater Contract Provider Agreement for mental health services, and PRIMUS/NAVCARE clinics. Evaluation plans have been developed for these projects, which will permit appropriate project comparisons. Other demonstration projects include a long list of Congressionally mandated activities, most of which are targeted to particular types of care or providers, such as chemical aversion therapy, chiropractic care, marriage and family therapy, home health care, biofeedback and others. Evaluation plans have been or are being developed for these Congressionally mandated projects, as well as several other ongoing, limited scope health care delivery demonstration projects initiated by DoD.

In summary, a substantial flurry of Congressional and DoD activity during the past several years has produced an extensive set of program revisions, initiatives and demonstrations. The most significant of these falls into three major thrusts, the execution of which will dominate the CHAMPUS reforms agenda during fiscal -- years 1989 and 1990. First, dramatic cost savings brought on by CHAMPUS payment reforms will continue to grow as DoD proceeds with nationwide implementation of the PRO program and potential payment method refinements. Second, the Partnership Program, Alternate Use Test and related activities will seek to restore levels of health care services in military facilities, when more cost-effective. And third, as the implementation and evaluation processes go forward on the three managed care demonstrations -- CRI, CAM, and FI-PPO -- a composite managed care model, incorporating the lessons learned and most advantageous features of each project, is expected to emerge.

Senator INOUE. Before I call upon Senator Stevens to present his questions, I would like to commend you for bringing together all of the services and having a unified approach to medical care, and especially in the presentation of the budget.

It is fine for the services to have the feeling of being autonomous, but in this area I do not see why a sailor should get less service than a soldier or airmen getting better than the rest of them. And I think all of them deserve the very best, and so I commend you for what you have done, sir.

Senator Stevens.

AIDS RESEARCH

Senator STEVENS. Thank you very much, Mr. Chairman.

I have had several interests, Dr. Mayer, over the years in your area, and one of them has been in the area of research, particular-

ly the AIDS research. I still believe that you have the capability through the Department to make significant breakthroughs in that extremely esoteric area of research.

It is my understanding you have made some significant contributions since we initiated the program.

Dr. MAYER. I think so.

Senator STEVENS. Could you tell us, has the work that has been performed by the Army, for instance, been sufficient to continue the level of funding that we have insisted on in the past years?

Dr. MAYER. Absolutely. While we are not on the brink of inventing a new vaccine overnight or staving off the ravages of this disease indefinitely, I think that the very excellent research the Army is conducting, is among the finest that is being done anywhere in the world. It is being done in close cooperation with the National Institutes of Health and with the Centers for Disease Control.

The amount of funding that was given was excellent. It got the program started. There is a major one-of-a-kind research and treatment unit being paid for out of these research funds at Walter Reed.

I firmly believe that the funding for this truly devastating infectious disease research should continue at approximately the level that the AIDS Commission recommended, which, specifically the Admiral said should be about \$20 million a year. I think that is a very reasonable estimate.

Senator STEVENS. Well, one thing that bothers me is, I think I was the one that insisted the Army get involved, and it was supposed to be research. It is my understanding now that the moneys have been turned over to experimental care research; is that right?

Dr. MAYER. Well, there is research being done in a whole variety of different areas.

Senator STEVENS. That was earmarked money for research, basic research into vaccines for AIDS. It is my understanding that you have now changed that to be not a question of cure or prevention, but care of AIDS patients within the military; is that correct?

Dr. MAYER. Not entirely; no, sir.

Senator STEVENS. Is it partially correct?

Dr. MAYER. It is correct that the research that is being done on AIDS is partly in search of a vaccine, partly in search of greater detail in the epidemiology of the disease, partly with respect to the treatment and management of cases of the disease.

You cannot restrict research in a valid scientific way to just narrowing it down to one thing—the hope for a vaccine. That is our hope, of course, and there is AIDS research directed that way in the National Institutes of Health as well.

But the clinical research that we are doing on the disease is equally necessary to an understanding of its management over the long haul. That clinical research necessarily involves some care of patients. We are not using research money just to finance care of AIDS patients. As soon as a patient develops symptoms of AIDS, DOD is able to remove that person from service and turn them over to the Veterans Administration.

But there is a period of time during which the disease is developing, during which there is great uncertainty as to whether the individual is actually fit for duty or not, whether he is truly disabled.

There is very necessary research that has to be carried on with respect to the prolongation not only of life, but of effectiveness on the part of the soldier. That is militarily relevant research.

Senator STEVENS. I have got to tell you that, I am no longer chairman of this subcommittee, but when I was, that was one of the things I discovered, that you had a unique unit in the Department of Defense that had a track record over a period of literally decades, that did not have the money to get involved in AIDS research.

We made that money available. We insisted on it becoming available for a long-term research program. There is no request before us this year, and I have got to tell you I am not going to insist on putting money into that this year, because it has been my information that that money has been moved over into other agencies of the Department, both in Army and in Defense.

And it is no longer being used exclusively by the group that has the capability to go into very esoteric research and the people who were capable beyond question, that throughout the profession they were the best, the best of the best.

Now, I want you to know I am extremely disappointed, as the one that initiated that idea and the one who insisted on the money being made available, that it no longer is dedicated to the unit that had that unique capability. And it is just not going to go any further.

The chairman can do what he wants to, but as far as this Senator is concerned, I think that the military has again missed a chance to do what it did in the period of vaccines for malaria or other things, where there were people within the military who had the competence and capability and the dedication, but did not have the assets to do the job.

Senator INOUE. Will the Senator yield?

Senator STEVENS. Yes.

Senator INOUE. I support you.

Senator STEVENS. I assumed my friend would.

I just think that you have a job to do in terms of military medicine and you have done a good job, all of you have. I do not criticize that. But I at times think, when we try to use specific capabilities of the military and say, "Please do this for us," that the Department of Defense ought to be willing to do it.

CHAMPUS

The chairman has mentioned CHAMPUS, you have. I congratulate you on CHAMPUS activities. That is not a neglected budget. During the period of time that I was chairman, the CHAMPUS moneys doubled, and they have doubled since.

It is not an area of the Department that has been in any way treated badly as far as the Congress is concerned. Now I am worried that the concepts that you have mentioned are not going to give us the ability to bring these increased demands in line.

I do not think it is possible for us to project now that we will be able to double CHAMPUS expenditures each 4-year period in the 8 years ahead of us.

Dr. MAYER. We agree.

BASE CLOSURE

Senator STEVENS. We have done it in the past. Now it seems that there has to be some way to assure that military medical facilities are used to the maximum extent possible, to maintain those costs.

I listened carefully to what you were saying and I am hopeful that they are going to be successful. For instance, we are just going through a process of closing major medical facilities at bases that are closing. What have we done concerning the use and distribution of those facilities and personnel?

I did not see anything in your statement about that, Doctor.

Dr. MAYER. The Base Closure Commission calls for the closure of the Presidio of San Francisco, which is the location of one of our major Army medical centers, Letterman. That hospital is a major resource for graduate medical education, which is the way we supply ourselves with the critically needed specialists we must have to be ready for war.

Across the bay from Letterman is the Oak Knoll Naval Hospital, Oakland Naval Hospital. It also has training programs. It has a somewhat larger percentage of active duty population.

We had established a joint San Francisco medical command, staffed by both Army and Navy, in the bay area, even before the Base Closure Commission came about, in order to ascertain the best future for a medical facility in that area.

It will be possible to absorb some of the patients and some of the training programs from Letterman at Oakland, but not all. That group is early in the planning phase. After all, the hospital cannot be closed for, I think, 5 years after the Commission's recommendation is accepted.

The planning now is directed toward the absorption of patients and those training programs that will have to be exported into other facilities up and down the west coast and throughout the country, wherever the Army decides it is best to carry on the programs.

Similarly, the Base Closure Commission has recommended the closure of Philadelphia Naval Hospital. Philadelphia, when I was an intern some 40 years ago, had more than 5,000 patients. Its average daily census this year has been 31 patients.

We need some hospital capability in Philadelphia, particularly because it is an extremely costly area to obtain civilian health care services under CHAMPUS, and that is why we have engaged, I think quite successfully—we are near completion, I believe—in a formal arrangement to move the entire capability of Philadelphia Naval Hospital, actually enlarged, to the new Veterans Administration hospital which is nearby in Philadelphia.

There will be a reduction to a sort of standby status of Fort Dix. We have an Army hospital at Fort Dix. It is not fully utilized, but it is an active hospital. Fortunately, before the Base Closure Commission was established I had established a joint health services system throughout the Delaware Valley, incorporating people from Army, Navy, and Air Force, with a view toward planning the future to assure the access of those patients currently using Fort Dix, Fort Monmouth, Philadelphia, and McGuire Air Force Base.

Now, there is going to be an impact on some other hospitals, perhaps as many as 30, not by closure so much as by, perhaps, an increase in the demand made on those hospitals.

Senator STEVENS. Well, that is where I want to go next. It seems to me that the Department ought to have a strategy that has been developed to deal not only with the closure of the bases recommended by the Commission, but to deal with the increased workload that is going to go to other areas as a result of the consolidation of the facilities, of the functions, that are coming out of the bases that are closing.

Is there such a plan?

Dr. MAYER. Absolutely. The plan is not finished.

Senator STEVENS. Well, would you share that with us?

Dr. MAYER. I cannot because the plan is not yet finished, sir. The Base Closure Commission's findings were only published 2 months ago. The planning has already begun for how to adapt to the changes that that Commission's recommendations, if accepted, will force to take place.

As far as having a final plan at this point, until we know exactly how many troops are going to move from one place to another, whether there will be reductions in some places or improvements in another, that information upon which we have to base our medical planning decisions is as yet incomplete. We and the three services are actively engaged in assessing the precise impact of the base closure to the degree that we can.

MEDICAL ASSETS—BASE CLOSURE

Senator STEVENS. Well, how about just the medical assets? Certainly we have all known what was under review, and the Department even sooner than we did. And it would seem that as far as the medical assets themselves in terms of their redistribution throughout the Department, that there should be some strategy developed.

The base closure recommendations are not a matter of conjecture, they are going to happen. There is no way for us to amend them and they are going to be adopted. Clearly, that has been known.

Dr. MAYER. I expect that that is true.

Senator STEVENS. Is there a strategy for allocating the personnel and the resources from the medical facilities and the bases that are to be closed throughout the country?

Dr. MAYER. If you are asking for specific numbers of doctors, nurses, and corpsmen that I am going to move from Fort Dix to Fort Bragg, no, there is no such strategy. The strategy is totally dependent on whether Fort Bragg increases in the number of soldiers and families who live there, what is going to be adaptable in Oakland from what has to leave Letterman.

The Commission's findings were very close hold. We did not have them until you did, until everybody publicly did. We had no certainty whatever. I did not know if they were going to close Fitzsimons. I did not know if they were going to recommend that we keep Philadelphia.

I did not know any of those things, and neither did anyone in the services. But we cannot have a plan for shifting medical personnel around until we know the detailed plans of all the Armed Forces for shifting the personnel that the medical personnel are going to serve. Once those plans are established, we will know where we are going to move people and where we are going to move training programs.

The planning, as I said, started the instant we learned what the final recommendations of the Base Closure Commission were. I think each Surgeon General in the later presentations will be able to tell you the kinds of thinking that have gone into it.

We have a list of every conceivable base that may be impacted directly or indirectly by this base closure business. But we do not have final facts on which to base a final plan so we can give you absolute numbers or names of who we are going to move from where to where.

FUNDING BASE CLOSURES

Senator STEVENS. I regret I am not going to be here after 11. I have to go to another subcommittee, but I am interested in this.

Is there enough money in this budget request now to allow for that planning? Has that been taken into consideration as far as this budget is concerned? The impact of what I am hearing now is the budget was not prepared on the basis that—I think most of us knew what bases were going to be included.

Now, we were surprised at some that were not included, but there were not many surprises in what was included, and I do not think the military community should have been surprised. It has been talked about for years.

Is there a request in here for money for the services to make those adjustments or at least make the plans for the adjustments for 1990?

Dr. MAYER. Senator Stevens, the planning capability of the medical departments of the Armed Forces, without an additional budget request, is perfectly adequate to do the initial year's planning that the Base Closure Commission's findings will impose upon us. If in future years additional money has to be invested for planning purposes, some attempt will be made to put that into future budgets.

You are quite accurate, no special money was put into the budget that has been submitted by the administration to do the planning, at least the medical planning, because we are able to do the medical planning with the capability that we have in hand right now.

There is a Base Closure Commission account, as I understand it, being set up by the Comptroller in the Department of Defense. But we did not make any request for it. We will surely next year if it becomes necessary.

ALCOHOL ABUSE AND SMOKING CESSATION

Senator STEVENS. Two last things. One, let me commend you. We all live with our memories of the time that we were in the military service, and mine is a memory of everybody smoking and everybody drinking PX liquor.

As I said once before this month, I think you have changed a lot of the climate in the military concerning smoking and in terms of the role models of people, such as drill instructors and other people involved in basic training. And I think you and your colleagues that are there now at the Department deserve a great deal of credit for being willing to step out in these areas.

Do you have any other initiatives to deal with those subjects? All you have to do is go through the veterans hospitals or some of the veterans homes and see our generation's colleagues from the services in wartime. Many are affected by emphysema, the effects of a long life of smoking, and others have the effects of excessive use of alcohol.

We ought to talk about it. Now, it would seem that that lesson alone ought to be sufficient to increase the activities as far as trying to convince younger people coming into the military now that there is no need to have the use of either alcohol or tobacco to be capable in the military sense.

Do you have any other plans for that? I congratulate you and your colleagues. I think you have done an excellent job. I remember the meetings we had with you and your predecessor.

What can we see on the horizon of any future activities in this regard?

Dr. MAYER. I think that, as you say, we have made more progress than many of us thought was possible. Our hospitals are essentially smoke-free.

I still continue to wish for a cessation of the Armed Forces subsidy in any form of alcohol and tobacco, which means I do not believe that we should sell cigarettes and whiskey so much cheaper than it is sold outside that we are implicitly endorsing and encouraging its use.

I am not a prohibitionist.

Senator STEVENS. Nor are we. We tried that. Today our two States are the only two States that still have the concept that our military facilities pay the same cost as the cost of tobacco and alcohol off-base. But we are the only two.

The rest of the country knocked out our initiatives of 4 years ago and 3 years ago that Senator Inouye and I worked on.

Dr. MAYER. I will continue to press for that. I do not think the commissaries and exchanges should sell those substances at any less than what they are available in the civilian community.

RECRUITING AND RETENTION

Senator STEVENS. Lastly, I am told by my staff that all three services have a severe problem in recruiting now and in retaining physicians, surgeons, nurses, and professional people in the military medical services. We have agonized over the pay issue and we may do that again. At least for the noncongressional area, at least, I hope we will.

But short of that, as I understand it your answer has been similar to that of NASA and some other areas, that you would like to target particular people for increased bonuses in critical specialties. Is that correct?

Dr. MAYER. Not altogether. It is true that, responding to congressional direction, we have targeted those specialties that are most critically short in case of war for the highest bonuses.

Second, we have recently, proposed increases in physicians' pay that give the largest additional bonuses to those physicians who are in shortest supply, but also tied to the fact that these are the physicians who suffer the greatest disparity in what we can pay them and what they can make outside of the service.

Senator STEVENS. Let me ask you this, doctor. When we examined the problem of pay at NIH—and I did that in another committee—in great depth, we found that, lacking the ability to recruit people in NIH, a system was devised of grants to specific nonprofit organizations which hired the same specialties at the market cost of those specialties.

Have you devised a similar system in the military? Do you have a system of contracting out for civilian physicians, nurses, or professional people anywhere in the military to fill vacancies?

Dr. MAYER. We have such a system throughout all of the services.

Senator STEVENS. And I am one who believes that having such a system now, it has been used to take the pressure off of adjustments in pay for everybody. How extensive is that and how much are you spending?

Dr. MAYER. I cannot give you a dollar figure because I do not know the total cost of such contracting. We do both personal services contracting and something called the Partnership Program, in which we contract for a group, for example, of physicians to provide an entire service, like the emergency room service or even a family practice clinic.

We are increasing the emphasis on doing that. But there is a point of diminishing returns. For example, if we contract with a pathologist, and this is a specific actual instance, we pay the market rate which results in that physician working side by side with a military physician, with the contractor making three times as much money.

I cannot keep my own physicians that way.

Senator STEVENS. That is what happened at NIH and that is my worry.

Dr. MAYER. It is a worry. There is a limit to how much we can do that.

Senator STEVENS. Are you using nonprofit corporations created specifically in specific areas for that purpose?

Dr. MAYER. No; we are not using foundations or nonprofit corporations, except that when we contract with a group of physicians to deliver emergency room service, for example, but it is not exactly the same.

They are not in turn hired by a third party. We can do that kind of contracting directly, and that is part of this partnership program whereby we are trying to use a small but substantial amount of CHAMPUS funds to enable us to enter into partnerships with civilian physicians to deliver services in our hospitals that we cannot deliver ourselves because we do not have enough of the right kind of doctors.

Senator STEVENS. But if you do that by contract, you are going to end up like NIH and you are not going to have the doctors in the military that will be able to do it day in and day out. And we have not been able to hire a medical researcher at NIH for 10 years now.

Dr. MAYER. There is that risk. We have some safeguards built into it by the fact that a very large number of our doctors are serving us because they owe us time. But we are beginning to see problems with doctors who fulfil their obligation and then leave.

This is a big part of the problem. So partnership and personal services contracting will help to solve our problem in the short run, but in the long run we must raise remuneration for our physicians, not just the superspecialists. The basis for specialty practice are the family practitioners and pediatricians and the general interns who see the patients first, who sort out the ones who need to go to the specialists, and who send the specialists the appropriate patients.

Senator STEVENS. What if we devised a system that was sort of insurance against a future draft, in the sense of saying to these young doctors coming out now that, if you pledge you will give us so much time through your medical career, we will guarantee you you will never be drafted by the Federal Government?

Dr. MAYER. That is an interesting idea.

Senator STEVENS. I advise you to try it, because if it does not work soon we are going to have to go to the draft. The system is breaking down now and you are losing those obligations that you had in the past. The new generation is not making those commitments.

Dr. MAYER. Yes, sir; they are. The reason they are is that over 75 percent of our accessions are people who we have paid for their entire medical education.

Senator STEVENS. All right, but that is a very limited crowd, though, really.

Dr. MAYER. Yes; but those are my doctors.

Senator STEVENS. Yes; but it is still a very limited crowd in terms of the future needs. You are looking at the demographics of society with a downturn of available manpower, womanpower, into the 1990's and into the early part of the next century.

Now, with the downtrend as far as the availability of people, you have to have some way to attract people in the military services.

Dr. MAYER. Yes, we do.

Senator STEVENS. And one of the ways you ought to attract them there is to give them an offer you cannot refuse: You sign up now and give us a commitment through this period of shortage that there will be people here and we will not have to draft them, and we will guarantee you we will not draft you.

Dr. MAYER. To a degree, that is exactly what we do in our Reserve programs, is it not? As I reported, we have a 56,000 increase in our Reserves.

Senator STEVENS. There is an increase there, but I think to a great extent that is because a lot of the people from this generation, the Vietnam generation, did not have such a bad experience after all in terms of their service with you in the medical portion.

You have a unique relationship there and those people are staying in the Reserve, and they have a connection. We see them over here in the facilities in the Senate Surgeon's Office, where they come back and just volunteer to come in once in a while, just to assist the facilities of the Congress.

Now, I think that is a unique role. But I also think that if you look at the nineties and the period right after the turn of the century, your successors and our successors are going to face some real problems unless we can devise a system now that will assure the flow of medical people into the military services.

I think an insurance policy might be a good way to look at it. But I commend it to you for thought, anyway.

Mr. Chairman, I have taken too much time. I appreciate your courtesy.

Senator INOUE. Thank you very much.

Because of the constraint of time, I will not ask questions. Instead, I will submit them to you, doctor, and ask for your consideration and response.

Dr. MAYER. Thank you.

PHYSICIANS' BONUSES

Senator INOUE. However, I would like to make one observation, because you indicated that in establishing the special bonuses you took into consideration the pay schedule or the income schedule in the civilian sector. I think it would be well to note that certain specialties command a higher income because of the higher cost, and the cost, much of it, related to the risks involved in malpractice suits resulting in higher premiums.

And as a result, maybe an internist does not have that cost of malpractice suits and so his premiums are low and he may not command as much as say an orthopedic surgeon.

I have chatted with several general practitioner intern types, and they are quite distressed that they are not looked upon as being essential and important enough to receive these bonuses. So I would suggest you go back to the drafting board, because we need internists just as much as we need neurosurgeons, believe me.

Dr. MAYER. We agree with you 100 percent, sir. We tried to avoid inequity as far as we possibly could. There is great internal conflict, with well-informed opinion on both sides of that issue.

I come down on the side believing personally that if we fail to adequately compensate our primary care physicians, family practitioners, even the general practice people, the pediatricians, the internists, then we are going to undermine the entire health care system, and we will not only lose the specialists, we will lose those people as well, and the quality is going to go down.

Senator INOUE. I would like to thank you very much, Mr. Secretary, and to assure you that I join you in your commitment to carry on our obligations to the men and women in uniform.

Dr. MAYER. Thank you, sir. I know that, and I want to thank this committee and you personally for the tremendous and thoughtful support that you have given to military health care.

Senator INOUE. And now we will call upon the Surgeons General.

I would like to assure the Surgeons General that I have looked over the testimony they provided and assure them that their prepared statements will be made part of the record.

Gentlemen, I welcome you to this committee. I would like to say before proceeding, whenever I sit with physicians there is a tinge of jealousy on my part, because many, many years ago I wanted to be an orthopedic surgeon in the worst way. So there are times I would wish I was sitting there instead of here.

But welcome, and I look forward to receiving your testimony. As I indicated, I have looked over your prepared statements and they have been made part of the record in total.

So please proceed as you wish. May I call upon Lieutenant General Ledford first.

STATEMENT OF LT. GEN. FRANK F. LEDFORD, JR., THE SURGEON GENERAL, DEPARTMENT OF THE ARMY

General LEDFORD. Thank you very much, Mr. Chairman. Sir, I am an orthopedic surgeon and all my life I have wanted to be a Senator. [Laughter.]

Sir, I am here with the three Surgeons General and with Dr. Mayer to tell you that we work together. These men are my friends, they are my colleagues, they are my counterparts. And I want you to know that the three Surgeons General, perhaps now better than ever before in recent history, do work together, and that is important to say.

Second, may I thank you for your support, and especially if I could thank you for the support you gave us for the fiscal year 1989, the year we are living in right now. You increased our medical program. You allowed us to continue health care in the Army this year at the same level that we had given in the previous year.

You allowed us to survive medical inflation, and medical inflation is growing at double the national inflation rate. You have allowed us to fund programs, some of them new like AIDS, barrier protection, and drug testing for recruits, and other programs that are absolutely mandatory.

MISSIONS OF DAILY CARE AND MEDICAL READINESS

Mr. Chairman, I was sworn in as the Army Surgeon General in June last year. I had my left hand on a Bible that was given to me by the very noncommissioned officers you talked to the other day, and I swore at that time that I had a twofold platform: first of all, to continue the momentum set in Army medicine; and second, to try to maintain the balance between our two missions: our missions of daily care and medical readiness, wartime preparedness.

So these missions are both competitive and complementary. I would submit that they are far more complementary than competitive. I would submit that what we do every day that we have talked about so much already is part of readiness.

It gives us a fit force, a select force. It allows our soldiers to concentrate on their jobs, rather than the health care of their families and the monetary problems thereof. And perhaps most importantly, I would tell you that in wartime our mission is to treat the sick,

prevent disease, and treat the wounded, and that is precisely what we do every day in peacetime.

And I would tell you, sir, that what we do in peacetime is what guarantees you a medical force that can go to war tonight.

HOSPITALS PURCHASED

I want to tell you, sir, that our momentum in medical readiness is positive. Like Dr. Mayer has said, I can tell you, we are proud to tell you, that the Army has purchased 101 DEPMED's hospitals. We have fielded 21 of them.

When I was the command surgeon in Europe, I put my hands on those hospitals. They are there now, and that is something that did not exist for the previous 40 years, when we had a Reserve force that had no medical equipment.

Recently we had a disaster in Ramstein. It generated 500 casualties in a microsecond. And I want you to know that, in cooperation with the Air Force and the Germans, we triaged and removed from that field in 77 minutes those 500 casualties. And that is because we were prepared, because we worked together, and we had a plan.

In daily care, in the Army at least, our workload has increased. Now, you may have seen some numbers that lead you to think otherwise. That is not the case. We have more admissions. We can document it. We have more outpatient visits.

But we have a shorter length of stay, and I would say, sir, that a shorter length of stay means better medical management. We are doing our job right, and I think we can show you that we are getting the best possible mix out of the direct care system and the CHAMPUS alternatives that you have already spent a lot of time on.

QUALITY ASSURANCE PROGRAM BEST IN NATION

Like Dr. Mayer, I am proud of our quality assurance program. It is the best in the Nation and the Nation is patterning itself after us.

We continue in the Department of Defense to be the Nation's largest and, I think, the best medical educator in this Nation, ranging from corpsmen to neurosurgeons. And our scholarship programs are dynamite. These scholarship programs give us the best young people in America. We are proud of them.

RETENTION RATE FALLS

So I have given you some things that we are proud of that are good. But there are clouds on the horizon. I worry about a recrudescence of the 1970's. In the Army at least, and I believe my colleagues will tell you somewhat similar stories, doctors are beginning to vote with their feet. In a period of 5 years, our medical officer retention rate has fallen from 72 percent to 41 percent.

And so the only way we can offset that is by bringing in more and more of these fine young people. What we must concentrate on is ways to retain the good folks we already have.

Nurses could be an even greater problem. Our nation is a competitive arena. Fifteen percent of the nursing spaces in this Nation

are vacant today, and so we in the DOD have to compete; and yet, we do not offer a competitive wage for our civilian nurses nor a competitive entry wage for military nurses.

—And then we do dumb things. Dumb things like what General Rumbaugh told you about: We do not have a parking garage at Walter Reed and the nurses have to go out and move their car every 2 hours. And I submit that we have to fix things like that.

And lastly, sir, you spoke of big weapons systems versus people and you spoke about General Rumbaugh. And I tell you, we lost a great American when we lost the service of General Rumbaugh. And I lost a friend. General Rumbaugh said before he died, and this was his favorite quote: "Walter Reed is the Army's largest live fire range."

So that is my opening statement. I am at your leisure.

Senator INOUE. I thank you, sir.

[The statement follows:]

STATEMENT OF LT. GEN. FRANK F. LEDFORD, JR.

Mr. Chairman and members of the Committee, I am Lieutenant General Frank F. Ledford, Jr., the Army Surgeon General. It is an honor to have this opportunity to appear before this subcommittee for the first time to discuss the Army Medical Department (AMEDD) and our FY 1990/1991 budget request. We are all aware that the budget before you was submitted by the outgoing administration. The Department of Defense is revising the FY 1990/1991 biennial budget based on new guidelines. This subcommittee has played a valuable role in helping the army not only to achieve goals aimed at increasing our wartime capability, but also to achieve goals aimed at ensuring that eligible beneficiaries have access to quality health care. And for that I thank the Committee.

I would like to especially acknowledge the Committee's support of the FY 1989 budget request. Your initiative to increase the medical program will allow us to maintain the FY 1989 level of care. It also allows us to fund such programs as the diagnosis related group implementation, pre-accession drug testing, aids barrier protection and other mandated medical programs.

The AMEDD has two distinct but interrelated missions. Simply stated, they are (1) To maintain the peacetime health of the active force and to be prepared to attend the sick and wounded in time of war and (2) To provide a health benefit as a condition of employment to eligible beneficiaries. This definition of the AMEDD missions was written in the final report of the Defense Resources Management Study (Rice Commission - page 81). Imbedded in those two missions are also the inherent responsibilities to ensure that the Army health care system is properly manned, equipped and sustainable, and to ensure that we have an aggressive and extensive research program to protect the lives of soldiers against disease and health hazards wherever they may be deployed. The FY 1990/1991 budget request was developed with these missions and responsibilities in mind.

Two years ago Lieutenant General Becker, My predecessor, informed this subcommittee of the AMEDD's initiatives to improve medical readiness and to increase access to our peacetime health care delivery system. Those initiatives have elevated Army medicine from the poor morale and checkered care of the post-vietnam war days into an era of renewed respectability. I plan to continue that momentum.

Progress in the area of medical readiness continues to be made but much remains to be done. Equipment and personnel shortages remain the two most critical limiting factors toward achieving our medical readiness objectives. As reported to you during previous hearings, correcting deficiencies is a lengthy process.

Equipment shortages exist in the active components as well as in the reserve components. Those shortages have been identified in the field type combat hospital units and in the battalion and division level units. Procurement of deployable medical systems (DEPMEDS) is the programmatic solution to equipment shortages in the field hospital units; acquiring critical items of medical materiel is the solution for the other units.

DEPMEDS, as you know, is a tri-service effort to standardize equipment used by all field type combat hospitals. On September 28, 1987, the first unit was equipped with DEPMEDS. To date, a total of 101 hospital sets, plus a training set, have been procured. Of the 101 sets procured, 21 DEPMEDS sets have been fielded. The fielding of DEPMEDS to these hospitals equates to a total of 6480 beds, which is only 10% of the total number of beds to be procured. Fifteen of the hospitals fielded are in Europe, five hospitals are located in the United States and the other one is located in Korea. At the end of FY 1989, the Army will have procured another 14 DEPMEDS sets. The FY90-91 budget request includes funding for an additional 14 sets, which increases the total number of sets procured to 125.

Reserve component units have also benefitted as a result of the

DEPMEDS acquisition program. Because of the DEPMEDS fieldings, three reserve component units were activated and fielded with displaced Medical Unit Self-Contained Transportable (MUST) equipment from active component units that received DEPMEDS. The Army National Guard and the Army Reserve units have also received a total of 18 minimum essential equipment for training (MEET) sets. These sets will enable those units to train at their home station. The 18 MEET sets are only a fraction of the total number of sets to be fielded under this vital program.

Training on this new DEPMEDS equipment has been provided to 21 reserve component and 5 active component units. Operator training and doctrine and tactics training for the active component units were conducted by a team from the Academy of Health Sciences at the units home station. Training for 20 of the 21 reserve component unit was conducted at the new equipment training site located at Camp Bullis, Texas. The other reserve unit, the 115th MASH, Washington, D.C., was trained at our newly established regional training site at Camp Shelby, Mississippi. That site opened for training on 15 January 1989. I will discuss further the regional training site later on in my statement.

Another area in which progress has been made is in the acquisition of critical items of medical materiel for battalion and division level medical units. This program has been under way for several years now and is essential if we are to provide care within the combat zone. For example, some of the items that we have procured include medical aid bags, dental x-ray sets, lab sets and medical clearing station sets. We also plan to purchase defibrillators and low capacity x-ray units. I might add that this acquisition program is for both active and reserve component units.

As I stated before, personnel shortages continue as a concern in maintaining medical readiness. These personnel shortages exist primarily in the Medical and Nurse Corps of the reserve components. The Medical Corps shortages exist in the critical specialties. We estimate the active and reserve physician requirement for anesthesiology, general surgery and orthopedic surgery to be around 5,749; whereas, our current inventory is slightly over 1,950 physicians. Naturally, our recruiting efforts are geared toward attracting those critical skills. For example, beginning this fiscal year, we have implemented a program called the National AMEDD Augmentation Detachment (NAAD) which will offer Army Reserve physicians and nurses in critical skills flexible training programs and will eliminate geographic constraints which impact on both recruiting and retention. The Army National Guard is considering a similar program for its members. In addition, the Army has increased the number of Active Guard/Reserve Recruiters dedicated to nurse and physician recruiting by 75.

To help solve some of the nurse recruiting problems, the Army, last year added 40 nurse recruiters and 13 nurse counselors. In addition, Army Nurse Corps Officers in critical skills are now eligible for the NAAD program. However, the jump in civilian nurse salaries has made it impossible for the reserve components to financially compete with civilian weekend opportunities. The current total estimate of nurse shortages is approximately 14,500.

When I was the Commander of 7th Medical Command in Europe I was actively involved in a readiness initiative called "warm basing". Warm basing is a rapid method of rendering wartime general hospitals fully operational in a short notice war. We can do this by partially establishing a 1,000 bed general hospital medical equipment set at its intended wartime site. Existing facilities, such as former warehouses or factories are ideally suited for this purpose and significantly shorten the time necessary to make these hospitals operational at the start of hostilities. We plan to warm base six general hospitals, representing 6,000 beds, by 1994. The first warm base hospital opened in the Netherlands in June 1987, and the second one in the United Kingdom in August 1987. We

intend to warm base other hospitals in Belgium, the Netherlands and the United Kingdom.

Training is another area in which we have made progress. As I mentioned earlier, we are training reserve component (RC) units to use DEPMEDS equipment at Camp Shelby, Mississippi. Camp Shelby is a regional training site-medical (RTS-MED) that has recently opened to train RC hospital units. There are 6 other RTS-MED planned to be activated by 1992. Each RTS-MED will consist of a standard five acre training site and building complete with classrooms, biomedical equipment maintenance facilities are key to the unit level sustainment training necessary to ensure National Guard and Army Reserve units are prepared to perform their wartime mission.

I am extremely pleased to inform you that we have expanded the combat casualty care course (C4) to include reserve components. The C4 course is an 8-day, Tri-Service course designed to prepare military medical professionals to successfully function at the forward points of the casualty care system on an integrated battlefield during mid-to-high intensity conflict. Providing RC clinicians with this training opportunity will improve medical support on the battlefield. In addition, we are providing an intensive 3-day program of surgical skills enhancement to obstetricians/gynecologists (OB/GYN). These physicians can then be used during wartime as members of the general surgery team. Thus far, we have trained approximately 150 physicians from each service.

The goal of the Army Health promotion program is to maximize combat readiness and mission performance. A fit soldier, capable of performing under the demands of the modern battlefield, will be an effective combat multiplier.

Since the establishment of the health promotion program in 1987, we have targeted goals in all areas of life-style behaviors which include physical fitness, stress management, tobacco usage, nutrition, substance abuse and screening for cardiovascular risk factors. The Army Medical Department has screened over 100,000 soldiers using the Army specific health risk appraisal assessment.

This computer assisted tool provides the needed feedback to the soldier for making the necessary health, fitness and spiritual life-style modifications for a long and productive service career.

This program has far reaching consequences for insuring the medical readiness of our forces. Fitness equals combat readiness and fitness will ensure our soldiers can meet the challenging demands that our nation will face in the future.

The global spread of Human Immunodeficiency Virus (HIV) is continuing despite preventive measures that have been taken, reinforcing earlier concerns that this disease has widespread military relevance for the future. Of particular concern is the incidence and projected spread of HIV infection in this hemisphere. The devastating effect that HIV has had in other places, such as Africa, is well documented. It is clearly recognized that HIV infection is of significant military importance and the spread of HIV infections could adversely affect military operations world-wide. The disease severely threatens our emergency blood supply, especially under combat circumstances with a deployed force. In addition, it exacerbates tension in our relationships with both allies and other countries since HIV infection and AIDS are still regarded by many countries, especially in the third world, as the "American" disease.

The Army research effort is directed at preventing new HIV infections as well as preventing progression of newly identified infections in troops and other beneficiary populations. It emphasizes three major areas: (1) Immunoprophylaxis (vaccines); (2) Chemoprophylaxis (drug therapy); and (3) Behavioral Science (how to change behavior of individuals at risk). We have made several significant findings and have developed clinically useful staging system. Progression of every HIV infection to AIDS has

been shown to occur in the vast majority of cases studied. Evidence has been found that significant immunological dysfunctions may exist early in the course of the demographics of this disease. Screening test procedures have been developed that have exceeded 99.9% specificity and 96% sensitivity at a cost effective rate of around \$3.00 per individual tested. Finally, phase 1 and 2 testing of 2 potential vaccines and 2 new drugs are underway.

Additionally, we have implemented an aggressive health education effort to inform and educate both soldiers and other members of the military community.

Operating a peacetime health care delivery system is not the primary AMEDD mission, but it is a mission that we take great pride in performing. In recent years, the cost of performing that mission has risen, but the AMEDD's cost growth is less than the cost growth experienced in the civilian sector. We recognize that resources are limited and we accept the challenge to seek innovative managed care initiatives which will slow that rate of growth. Regarding the peacetime care operation, I would like to comment on its operation, highlight some of our managed care initiatives and present some of my most pressing concerns.

The AMEDD operates 49 hospitals and 290 dental clinics along with numerous health clinics world-wide. We also provide military staff for Brooke Army Medical Center operated under the executive agency of the United States Air Force as part of the San Antonio Joint Military Medical Command. We point with pride to the peacetime health care services provided in our medical treatment facilities. Over the past several years, workload accomplished by these AMEDD facilities has remained relatively constant. On an average day, we admit 1,114 patients, have 5,756 beds occupied, assist with the birth of 114 children, and provide care for some 18,322 patients. While the number of admissions has steadily risen, army hospitals continue to experience a decline in the average length of patient stay which decreased from 5.8 days to 5.17 days between fiscal years 1986-1988. This decrease is reflective of the national trend which results in part, from technological advancement, such as the use of lithotripters to non-surgically remove kidney stones, along with changing treatment practices like ambulatory surgery.

In spite of productivity enhancements, the AMEDD has not kept pace with the growing beneficiary population's demand for health care. We are not using our medical treatment facilities to full capacity. The most significant factor limiting full utilization is staffing. Consequently, when we cannot accommodate a patient's needs within the direct care system, we must refer the patient to the civilian sector under the CHAMPUS program. This alternative is more costly and generally not as acceptable by our beneficiaries as is care provided in the direct care system. Review of CHAMPUS non-availability statements issued by our facilities indicates that in FY 1984, Army hospitals accommodated 93.7 percent of our patients. In FY 1988, the accommodation rate declined to 92.0 percent.

The FY 1990/1991 budget request reflects a continuation of this stable workload trend. The budget request (\$2,588M) includes \$17.42M for the direct care component and \$846M for CHAMPUS. The growth in the direct care component reflects the nominal growth required to extend the FY 1989 level of care into FY 1990. The budget request also includes funds for the direct care system to accommodate the beneficiary population which we estimate to be increasing at the rate by 1/2 of 1 percent per year. We have also fully funded the CHAMPUS program.

Training of AMEDD personnel is extremely important if we are to accomplish our mission. Our graduate medical education programs are nationally recognized as a valuable asset. These programs ensure trained physicians are available to treat the medical needs of our patients. The largest source of physicians entering the

Army is from the Health Professions Scholarship Program (HPSP) and the Uniformed Services University of the Health Sciences (USUHS). These physicians are not specialty trained when they enter active duty. While they are undergoing residency training they are at the same time delivering care to DOD beneficiaries. The graduate medical education environment provides a solid basis to sharpen and challenge the skills of all participants in the training process, as well as to provide daily experiences that ensure readiness on the battlefield.

I identified staffing shortages as the most significant factor limiting full utilization of our medical treatment facilities. To overcome that situation, we developed and initiated the Army Medical Enhancement Program (AMEP), a program strongly supported by the Congress.

AMEP was initiated to provide responsible and efficient health care to soldiers and their families. It is the cornerstone of the Army's plan for achieving a 95 percent level of required staffing at medical facilities. The goal of the medical enhancement program is to improve the accessibility and the quality of care in medical treatment facilities. The first objective is to create a primary care model for all active duty families. The second objective is to improve the patient appointment system. This includes hiring more clerks and receptionists, as well as installing automation to assist in managing the scheduling process, while providing excellent data for management. A third objective is to obtain additional ancillary support personnel - nurses, physical therapists, occupational therapists, dieticians, corpsmen, lab, pharmacy and radiology technicians. These additional personnel will increase support for physicians in the clinical environment, relieve physicians from performing nonclinical duties, improve provider productivity and the effectiveness and efficiency of the health care delivery system, and support the Army Family Action Plan through improved access to care for military family members.

Last year, the AMEP initiative corrected some critical nurse staff shortages in emergency rooms and intensive care units which enabled us to meet accreditation standards. We were able to correct some physician shortages in radiology and emergency rooms, as well. We will achieve 80 percent of required staffing level by the end of this fiscal year. The personal services contracting component of AMEP is merely allowing us to replace the loss of our military physicians, it does not increase our capability; consequently, we are experiencing only small increases in our workload.

Recently, as a result of the Vander Schaff Study, the Office of the Joint Chiefs of Staff obtained approval from the Senate to reallocate 384 civilian spaces in FY 1990 and 360 spaces in FY 1991 to increase our direct system capability in CONUS. These additional spaces along, with the AMEP increases, will bring staffing levels to the 85 percent level by the end of FY 1991.

Opportunities to share health resources and thereby utilize excess capacity in either VA or DOD facilities are being pursued under the framework of the Health Resources and Sharing Act. VA and DOD cooperative ventures to maximize the use of federal health facilities afford mutually beneficial opportunities to expand service availability while promoting cost containment. Since passage of this law, the Army Medical Department and the VA have successfully negotiated over 36 sharing agreements covering all aspects of hospital services. Examples of services currently shared include inpatient and outpatient care, as well as neurosurgery, open heart surgery, specialty consultations and procedures, procurement of medical supplies and equipment, dental services, and CT Scans and other radiology services.

William Beaumont Army Medical Center (WBAMC) is continuing the joint venture with the EL Paso, Texas, Veterans' Administration outpatient clinic. This agreement currently allots forty

inpatient beds at WBAMC for VA use. The Veterans' Administration is considering construction of a new ambulatory care center adjacent to WBAMC which would replace an aging facility in El Paso and encourage further sharing of services between the facilities.

One of our most successful peacetime health care initiatives of recent years is the Primary Care for the Uniformed Services Program (PRIMUS). It was developed and implemented by the Army in response to congressional directives to improve access and convenience for the beneficiary, and to increase workload accomplished in military medical facilities and to provide an alternative to CHAMPUS. The concept utilized contractor operated primary care clinics as satellite facilities to existing military hospitals. The first PRIMUS clinic opened in Fairfax, Virginia, in 1985. The Army currently has ten PRIMUS clinics in operation - three in northern Virginia; one in Savannah, Georgia; one in Columbus, GA, one in Fayetteville, North Carolina; one in Killeen, Texas; one in Copperas Cove, Texas; one in Salinas, California and one in the Presidio of Monterey, California. PRIMUS program objectives are being met. PRIMUS has proven to be a cost-effective method of increasing direct care capability. The PRIMUS concept has been extremely well received, within the Army as well as by the other services (NAVCARE and Air Force PRIMUS clinic initiatives). Patients have been pleased and excited with these primary care clinics.

The AMEDD is also involved in a demonstration project in Europe to obtain urgent medical care for soldiers and their families stationed in small communities where 24-hour-a-day clinic operations is uneconomical in terms of staffing. Under this arrangement, the local clinic operates at full staff during normal duty hour to accommodate the needs of the community, while we have negotiated agreements with local German hospitals to provide care to our beneficiaries when the military clinic is closed. CHAMPUS makes reimbursement without patient co-payment. We expect the project to improve the morale of active duty members and their families in Europe and to ensure that quality health care is available to them without additional cost. There are thirty-eight European command clinics/hospitals (29 Army and 9 Air Force) eligible to participate in the project. To date, we have negotiated 22 agreements.

As you know, DOD transferred responsibility for funding CHAMPUS benefit claims to the services last year. The AMEDD welcomes this challenge, and we fully support the philosophy that the military treatment facility (MTF) Commander should be responsible for the health care services provided to the beneficiaries residing near his facility. In addition, the Congress gave the AMEDD authority to use up to \$50m in CHAMPUS funds for other than the payment of CHAMPUS claims when such use would improve the productivity of MTFs and produce net verifiable savings. The AMEDD, currently has approval for 10 such projects, and we are submitting an additional 9 projects to the Assistant Secretary of Defense (Health Affairs) (ASD(HA)) for consideration. We project those 19 projects will recapture or avoid approximately \$19.2m worth of CHAMPUS cost, with an expected net savings of \$8.0m in CHAMPUS for FY 1989.

The catchment area management demonstrations, required by the 1988 Authorization Act, will begin on 1 April 1989. Under this concept, the local MTF Commander will have responsibility for providing all health care services to eligible beneficiaries through either the direct care system or under CHAMPUS. The objectives of this demonstration are to provide the local commander with the resources and authority to develop the most cost-effective sources of care within his catchment area, to pursue alternative delivery mechanisms to augment the services available from the direct care system, and to improve beneficiary access to care by exploring all available options to meet their health care demand.

The concept has been designed and approved by ASD(HA) and will

be conducted at Ft Sill and Ft Carson. Current programs which provide staffing and service augmentation at the MTFs will continue to be employed. These include the DOD/VA sharing agreements and the military-civilian health services partnership program. Other contracts and negotiated agreements with the private health care sector will also be pursued. An enrollment system will be established for each location. To encourage 100 percent enrollment, an alternative system will be included at one site. Each activity will employ the "health finder" concept to assist beneficiaries referred to civilian providers. Concurrent evaluations as well as retrospective review will provide for control and proliferation of positive aspects of the demonstration.

The AMEDD Quality Assurance (QA) division continues to monitor our program to ensure that all our beneficiaries receive quality care. Our program is based on rigid enforcement of confidential peer review at each military medical treatment facility under the explicit and direct oversight of the Medical Corps Commander. The overall quality assurance program entails patient care assessment, provider credentialing, utilization review, and risk management.

We have received the results from the 1988 DOD contract to the Forensic Medical Advisory Service (FMAS), Rockville, MD, for external civilian peer review from Dec 1987 through Nov 1988. I'm pleased to report that this agency reviewed 19,000 cases (primarily high risk categories) and only 86 have been reported to date to represent unacceptable care. Of the 86 cases, 8 represent a possible major deviation from the standard of care. All of these cases had previously been identified by the MTF under their ongoing QA program. Although we would prefer not to have any such cases, the fact that the number is small and that these cases had previously been identified by internal review attests to the efficacy of our QA program.

The AMEDD's research arm, the Medical Research and Development Command, has five research programs with eleven subordinate units which focus on the health and safety of soldiers. Validated research efforts focus on medical biological and chemical warfare defense, infectious diseases of military significance, combat casualty care, including combat dentistry and military systems health hazard. The Army has been designated by DOD as the Executive Agent for Medical Biological and Chemical Warfare Defense and by Congress as the lead agency for infectious disease and combat dentistry research.

The research programs seek to improve ways to protect soldiers from infectious diseases they might encounter through deployment to endemic areas or exposure to biological weapons; to improve medical care on the battlefield by placing the best tools and techniques in the hands of the combat medic; to protect our soldiers from military environmental health hazards and from the health hazards posed by our own weapons, equipment, and vehicles. Other important areas include maxillofacial surgery and wound infection control; medical protection of soldiers from the effects of chemical weapons, and improved medical management of chemical casualties.

During 1988, some accomplishments made by our research arm are:

- (1) Completed development and fielded of ballistic-laser protective spectacles to contingency forces
- (2) Completed operational testing of new skin decontamination kit (xm291)
- (3) Completed concept evaluation program testing of individual chemical casualty resuscitation prototypes
- (4) Initiated full scale development of laser protective eye shields for aviators
- (5) Initiated production validation of the wheeled litter
- (6) Procured army developed anthrax vaccine for contingency requirements

As you can see, Medical Research and Development Command is an

important player in the Army. It provides the technology, technical information, and medical materiel to resolve unique military medical deficiencies, prevent casualties, enhance the return to duty rate and lighten the logistical burden of U.S. Forces.

The most pressing issue in the Army Medical Department is the retention of our trained physician work force. The Army Medical Department is essentially operating a "revolving door" system in which most physicians leave the service at the first possible opportunity to do so. The initial loss rates of our physician specialists have increased dramatically from FY 1984 to the present. This is problematic in that it manifests itself in a less experienced work force than we need to meet either our war or peace time needs. Although it is difficult to identify precisely specific causes and effects to determine why physicians choose to leave active duty, studies cited in the February 1989 report to Congress on Management of Military Medicine suggest factors that affect physician retention include, but are not limited to the following: professional job dissatisfaction; a perception of declining or inadequate resources, equipment, or facilities; excessive administrative duties; inadequate administrative and clinical support; and insufficient pay and compensation.

We in the AMEDD have long recognized these physicians dissatisfiers and in 1985 my predecessor initiated the Army Medical Enhancement Program (AMEP), an initiative I strongly endorse. As I mentioned earlier, the second and third AMEP objectives are aimed at relieving the administrative burden of physicians and providing additional ancillary support. We've made modest gains toward achieving these AMEP objectives and will continue these efforts as funding permits.

In the FY 1989 National Defense Authorization Act (P.L. 100-46, Sec. 612), the Congress addressed the physician retention issue by authorizing Department of Defense (DOD) to pay a one time medical officer retention bonus (MORB) during FY 1989. As a condition of this program, DOD was to provide two reports to Congress. The first, which was submitted 15 November 1988, required DOD to describe how the MORB would be implemented. The second report, which was submitted 1 December 1988, required DOD to prepare a comprehensive recommendation for permanent improvements to military health care provider compensation. Due to the complexity of the analysis, the initial reports addressed physicians only. Nurses and all other health professionals are being addressed at this time.

Internists, Flight Surgeons, Pediatricians, Family Physicians, Psychiatrists, and certain other primary care specialists were included as group 6 and 7 in the DOD (HA) prepared MORB plan submitted to the Congress on 15 November 1988. On 4 January 1989, following a review of quantitative data pertaining to historical retention rates and military-civilian physician pay differentials, the department issued a memorandum deleting group 6 and 7 from the MORB.

Since the preparation of the 15 November report, there has been a reduction in the number of Army physicians applying for training in primary care. As an example, we had only 25 applicants for the 26 pediatrics residencies that we are offering this summer and 73 applicants for 71 internal medicine residencies, whereas in the past there were far more applicants than positions available.

The Army Medical Corps is now experiencing decreased retention of physicians in the excluded specialties. We are now studying the feasibility of including these specialties in future physician bonus programs.

Another pressing issue in the Army Medical Department is the recruitment and retention of military and civilian registered nurses. In the midst of a nationwide shortage of professional nurses, the U.S. Army is thrust into a position of competition for scarce nursing resources within the health care industry. Civilian

agencies have raised salaries, marketed education and professional development packages, and improved the quality of life for nurses. The military services have not kept pace with all of these initiatives.

While there are several incentive programs, such as loan repayment and stipend programs, for the reserve components, the absence of incentive programs for the active component and civil service RN force has resulted in serious recruitment and retention shortfalls. For the active component, recruitment is down significantly. Only 9.3% of our goal has been achieved versus 23.7% this time last year. Actual losses exceed our programmed losses by 50%. Requests to join the career force are down 50%.

For the civilian component, vacancies have increased by 1% (15-16%) in the 1st Quarter of FY 1989. Virtually every medical treatment facility in the AMEDD reports recruitment and retention crises concerning civilian RNs.

Long hours, increased requirements, stressed resources, few incentives and civil sector competition are significantly impacting upon the delivery of quality and quantity of health care. In the absence of immediate action, the Army Medical Department could be faced with a shortfall of 900 nurses by the end of 1991 to perform our peacetime mission.

We have taken myriad actions to alleviate this downward trend. Some of these include:

- Increasing the size of the recruiting force
- Offering educational guarantees
- Relaxing age and work experience criteria
- Accelerating accession processing
- Increasing career status quotas
- Protecting training and continuing education funds
- Enhancing career opportunities for civilians

There is still much to be done. We are currently considering several other initiatives to enhance our ability to recruit and retain military and civilian nurses, and we hope to present them to you in the near future.

Your support in these areas is essential to maintain the viability of our current military health care system. Nurses are critical members of the health care team and are key to accessibility and delivery of quality patient care.

Lastly, I am concerned about our ability to recruit and retain other medical disciplines to include civilians. We anticipate problems in recruiting and retaining these individuals, as well. The active duty specialties, such as, Optometry, Physical Therapy and Clinical Psychology, are primarily fed by the civilian health care labor market. Changes in demand for health professionals in that market will affect the Army's ability to attract and retain those specialties needed for both mobilization and peacetime medical missions. The particular specialties which are of immediate concern are dental officer, physical therapy and occupational therapy, optometry, clinical psychology, pharmacy, and podiatry.

A special pay study has been initiated which will study the status of these disciplines in the three services. I hope that the study group's recommendations will assist us in recruiting specialists in these disciplines.

We have also experienced similar problems with the civilian work force, which comprises such diverse skills as nurses, pharmacists, optometrists and radiological technicians. The department is currently exploring possible solutions to this problem.

In conclusion, the Army Medical Department is proud of its service to the nation in peace and war. We are committed to providing quality health care to the soldiers and their families that we serve. The challenge that we face is going to be that of balancing our efforts. We must balance the resources we get and

use, balance the efforts we make in day-to-day care with those we make in readiness. The positive side of balancing our daily mission and the readiness mission is the fact that our most sophisticated mission in wartime is the same as our most sophisticated mission in peacetime. It's the care of real patients. We learn how to take care of wartime wounded, not by reading about it, but by taking care of the peacetime injured and sick.

The AMEDD has several initiatives to accomplish both missions. I am committed to maintaining the momentum of those initiatives and also achieving a balance between the two missions.

Mr. Chairman, that concludes my prepared statement. I will be happy to answer any of your questions.

BIOGRAPHICAL SKETCH

Lieutenant General Frank Ledford was sworn in as the thirty-seventh Surgeon General of the Army on June 16, 1988. General Ledford was born in Jacksonville, Florida on 22 April 1934. He received a Bachelor of Science degree from the University of Dayton and was awarded his Doctor of Medicine degree from the University of Cincinnati. General Ledford's additional medical specialty training includes an internship at Brooke Army Medical Center, San Antonio, Texas; a pre-specialty surgical residency at Womack Army Hospital, Fort Bragg, North Carolina; an orthopedic surgery residency at Letterman Army Medical Center, San Francisco, California; and a residency in children's surgery at the Phoenix, Arizona Crippled Children's Hospital. His military education includes the Army Medical Department Basic and Advanced Officer courses, the United States Army Command and General Staff College, and the Industrial College of the Armed Forces.

General Ledford is a Clinical Professor of Surgery at the Uniformed Services University of Health Sciences. He is a fellow of the American College of Surgeons, a Fellow of the American Academy of Orthopedic Surgeons, and a Fellow of the American College of Physician Executives.

General Ledford has held a variety of important command, staff, and clinical positions culminating in his current assignment as The Surgeon General. His recent assignments include Commanding General, Seventh Medical Command and Surgeon, United States Army Europe and Seventh Army; Commanding General, Letterman Army Medical Center; Chief, Medical Corps Affairs and Director of Professional Services, Office of The Surgeon General; Commander, Army Medical Department Activity and Martin Army Hospital, and Director of Health Services for the Infantry Center, Fort Benning, Georgia; and Commander, Army Medical Department Activity and Irwin Army Hospital, Fort Riley, Kansas. He has also completed assignments as Chief of Surgery for a 400 bed evacuation hospital in Viet Nam, Deputy Commander of the United States Army Hospital in Heidelberg, West Germany, and Assistant Surgical Consultant to The Surgeon General and Chief of Graduate Medical Education for the Army Medical Department.

General Ledford's awards and decorations include the Distinguished Service Medal, the Legion of Merit, the Meritorious Service Medal, the Army Commendation Medal (with oak leaf cluster), the National Defense Service Medal, and the Vietnam Service Medal. He also wears the Meritorious Unit Citation, the Republic of Viet Nam Campaign Medal (with two stars), the Republic of Viet Nam Gallantry Cross Unit Citation (with palm), Overseas Bars (2), the Overseas Service Ribbon (with numeral 3), and the Army Service Ribbon. General Ledford is one of the few American officers to have been awarded the Cross of Honor in Gold by the Federal Republic of Germany.

He is married to the former Marilyn Kain of Troy, Ohio. They have one daughter, Cheryl Lynn.

STATEMENT OF VICE ADM. JAMES A. ZIMBLE, MEDICAL CORPS, U.S. NAVY, DIRECTOR, NAVAL MEDICINE, AND SURGEON GENERAL, DEPARTMENT OF THE NAVY

Senator INOUE. Admiral ZIMBLE.

Admiral ZIMBLE. Thank you, Mr. Chairman. I appreciate all the remarks that have been made. I am going to keep my remarks extremely brief since I have submitted to you our posture statement.

My predecessors—Dr. Mayer, General Ledford—have very well expressed problems that are universal in scope and apply to the Navy as they do to his service. I must hope that, as an obstetrician-gynecologist, you are not going to show favoritism to my good friend Frank, because we all suffer from some of the same problems and constraints that are manpower driven.

READINESS DEFINED

There are some things I would like to say just as an addition. First, that readiness is not just medical readiness for us to be ready to move from peacetime to wartime. Readiness is also an obligation we have to keep the peacetime total force ready to go to war.

Part of that readiness involves our ability to retain sailors and marines because they have access to good medical care. That keeps retention up across the board for the full in-line strength, and that sailor on board the USS *Nimitz* in the middle of the Indian Ocean whose job it is to listen as a sonar man to the screws of an enemy submarine must be able to concentrate on that and not be concerned about his wife that may be back in Norfolk getting access to care for herself or for her children.

He has to be assured that we are able to provide that care without eroding his benefits and giving him the assurance of quality.

We have a quality assurance program that is exceptional, bar none, in all three of our services, and we are very proud of that. We continue to improve that quality assurance program.

LOW COMPENSATION ERODES COMPETITION

I would like to say that the average salary in the United States today, the average income for a physician—that is, net income before taxes—as computed by the AMA was almost \$135,000. That is the average. I feel that in military medicine, Navy medicine, and certainly the other two services, we have above-average physicians. Yet we have no physician that makes anywhere near that average salary.

We are not competitive. We do not ask to be comparable, but we do ask for the ability to provide enough compensation incentive, fiscal compensation, that we are competitive. We need it for the physicians, we need it for nurses, we need it for some of our health science colleagues, in which the gap is broadening. We need it in the dental community.

We have to look at every one of our communities to see where we are no longer competitive in the marketplace. When we are dealing with an all-volunteer force, it is important for us not only to recruit, but to retain. And in the medical professions, experience gives better quality. We age like a good wine, and I think for that reason it is important that we have the maturity in our medical departments.

I am very appreciative, therefore, for your initiative to remove the DOPMA end strength constraint from nurses, which will allow

us to have better promotion opportunities, better compensation, and a more balanced, mature nurse corps.

I am very grateful for your very strong interest in personnel in general, since that of course is our strong interest, in preventive maintenance and in casualty treatment personnel.

More importantly, I am very grateful for your specific interest in medical health care delivery.

Thank you, sir.

[The statement follows.]

STATEMENT OF VICE ADM. JAMES A. ZIMBLE

Good morning Mr. Chairman and members of the committee.

I am Vice Admiral James Zimble, Medical Corps, United States Navy, Director, Naval Medicine and Surgeon General of the Navy. Thank-you for the opportunity to appear before you today to discuss Navy healthcare and the critical Navy medicine items in the Fiscal Year 1990 Defense Budget Proposal.

This Statement will describe the state of Navy healthcare, identify some areas where we have made significant progress since this time last year, and highlight some of the more pressing issues with which we need your help.

I would like to clarify before starting that all of the budget figures which I will be covering today are from President Reagan's budget submission.

We have some good news. We have made steady progress toward eliminating shortfalls in deployable medical units, the linchpin of our wartime medical readiness. Our quality assurance programs have documented the high quality of the care we provide. We are now implementing our second generation quality assurance program that will streamline and improve our efforts. Most importantly, Navy people still tell us that they prefer to receive their healthcare in Navy facilities; from Navy providers.

All is not good news, however. I regret to say that the likelihood of our beneficiaries' continued access to the system they prefer is fading. We are having ever greater difficulty attracting and retaining high quality people. Our shortage of healthcare personnel is worsening. Mr. Chairman, less than 20 percent of the Navy physician specialists stay with us 5 years after they reach their "stay or leave" decision. This has serious implications for our training programs in that we are experiencing an unacceptable dilution of our experience level. Our good, young physicians are without the counsel and

wisdom of senior physicians--attributes which are developed after years of experience. These startling statistics make it crystal clear that we must improve retention.

These losses engender most of the initiatives you will hear today; initiatives directed towards attracting good people and retaining those good people who are now serving.

I must also tell you at the outset that mine is not a "gloom and doom" assessment or a "sky is falling" plea for help. We have serious problems that require sober analysis and treatment. But they are treatable; and with modest, not huge investments. We need your commitment to work with us for the long haul.

Overview of Navy Medicine

The Navy healthcare system exists to provide prompt and effective medical care to combat forces in time of conflict and to maintain the health status of active duty members in peacetime. Successfully accomplishing this mission contributes directly to the Navy's ability to sustain combat operations.

During peacetime we provide healthcare services to authorized beneficiaries using resources that will be needed during war. Dependents of active duty personnel and retirees and their dependents are provided healthcare to the extent resources will permit. Although our active duty personnel must receive first priority for medical services, it is by providing care to the remainder of our beneficiary population that our physicians gain the greatest experience, thus enhancing the Navy's ability to retain its quality professionals.

Our direct care system consists of hospitals and clinics managed through Medical Commands. The Naval Medical Command is responsible for the operation of 33 hospitals in the United States and overseas (four of which are comprehensive teaching hospitals and another four are family practice teaching hospitals), 200 medical clinics, and 172 dental treatment facilities. These are exclusive of facilities on U. S. Navy ships or in organic Marine Corps units

The Naval Medical Command also oversees medical research, investigating issues which will keep naval forces healthy and able to carry out their mission. This is accomplished through the Naval Medical Research and Development Command in Bethesda, Maryland. The Medical R and D Command has the responsibility for the Naval Medical Research Institute, Naval Health Research Unit, Naval Dental Research Laboratory, the Naval Medical Research Units, the Naval Biodynamics Medical Laboratory, the Naval Submarine Medical Research Laboratory, and the Naval Aerospace Medical Research Laboratory.

Also under the aegis of the Naval Medical Command are the Naval Aerospace Medical Institute, the Navy Ophthalmic Support and Training Activity, the Naval Medical Data Services Center, the Naval Medical Materiel Support Command, the Navy Environmental Health Center, and the Naval Health Sciences Education and Training Command. The Navy Environmental Health Center is the Navy's equivalent of the Public Health Service's Centers for Disease Control. It is responsible for tracking infectious disease, for preventive medicine measures, and for environmental and occupational health.

The Naval Health Sciences Education and Training Command (HSETC) operates the Naval School of Health Sciences and Hospital Corps schools. HSETC trains medical personnel and oversees outservice and inservice training programs.

We do people repair. This is maintenance, an essential logistics function with amazing similarities to the mission the shipyards perform; only more intricate, a lot more personal, and much more personnel intensive. Fifty-one thousand active duty and civilian Navy medical department personnel are available to staff our facilities as well as meet the operational requirements of the Fleet and Marine Corps. While these personnel represent fourteen percent of the Navy's officer end strength and six percent of the Navy's total active duty and civilian end strengths, our staffing levels fall short of the burgeoning healthcare demands. Over three and one half billion dollars are spent annually to fund our various activities.

Paradoxically, while 75% of our facilities are underutilized due to staffing shortfalls, nearly one third of this sum pays CHAMPUS claims

. For the past several years patient workload has been shifting from in-house to CHAMPUS. Navy outpatient visits decreased 21 percent and admissions 17 percent between FY-85 and FY-88. CHAMPUS outpatient visits increased 78 percent and admissions 42 percent over the same period.

Five factors contributed to this shift in workload:

- o A changing beneficiary population. Department of the Navy manpower has increased 12.8% since 1980. Not only has the active duty population grown in size, its composition has changed. Active duty members are more likely to have dependents and the retired personnel and their families are becoming increasingly older requiring more intensive and expensive healthcare for illnesses of longer duration.

- o The impact of our quality assurance program. In the early 1980's the Navy intensified its quality assurance (QA) program. While the QA program has, unquestionably, improved the quality of our services, it has drawn providers away from the delivery of care.

- o Ever present operational requirements. Navy healthcare providers must also support extensive forward-deployed operational requirements. Fully 14% of all Navy physicians and 28% of all hospital corpsmen are assigned to afloat Navy or deployed Marine units.

- o The increasing cost to deliver healthcare. The Navy faces the same systemic financial pressures faced by the private sector. Specifically, medical inflation is significantly greater than increases in the Consumer Price Index. The in-house portion of the medical budget has not fully reflected this higher inflation rate, resulting in restricted in-house workload capability. In addition, advancing medical technology requires continual investment in state-of-the-art equipment and techniques. New capabilities lead to new demands without any noticeable reduction in prior demand.

o The advent of new requirements: Recent initiatives such as performing pre-physical fitness exams, conducting HIV testing, and treating HIV positive individuals have reduced the amount of healthcare that could otherwise be provided. Students with special needs in the Department of Defense Schools are particularly deserving of our services; however, support for this very small population has required the investment of significant resources.

The shift from in-house treatment to CHAMPUS created many problems. Concomitantly, other pressures developed due to fiscal and policy decisions. As a result we have experienced extraordinary medical personnel recruiting and other personnel problems, skill training shortfalls, obsolete equipment, and poor facility utilization. The most significant areas of concern are addressed below.

o Navy's Graduate Medical Education Program (GME). GME plays a crucial role in recruiting talented medical personnel into the Navy and retaining them with the offer of training for a medical specialty (e.g., general surgery). Navy GME graduates are also the primary source of wartime critical skills physicians. The shift in workload from in-house to CHAMPUS limits the number and variety of cases referred to the teaching facilities thus reducing the range of training experienced by the physicians under instruction. Problems with retention of senior, experienced medical personnel put our graduate medical education programs in grave risk.

o Financial impact on beneficiaries. Retirees and their dependents, survivors, and active duty dependents can obtain healthcare from a Navy medical facility for a nominal cost (\$8/day) or obtain the necessary care in the private sector. The provider or the beneficiary can seek payment/reimbursement from CHAMPUS. CHAMPUS will pay up to 80% of the allowable charges above the deductible, while the beneficiary pays the balance. The recently approved catastrophic care provision limits each family's annual out-of-pocket expenses to the deductible, plus \$10,000 for retirees, or \$1,000 for active duty dependents. However, expenses below this amount place considerable

strain on the budgets of retirees living on fixed incomes and junior sailors and marines with families to support.

o Navy's financial burden increased. The Navy must pay both in-house and CHAMPUS healthcare costs. Since the government cost of providing care under CHAMPUS is greater than providing that same care in-house, the overall cost to Navy has increased as the CHAMPUS costs have grown. Indeed, CHAMPUS costs increased 46% from 1985 to 1987.

o Reduced morale and retention. The inability of Navy medicine to provide balanced in-house care to its beneficiaries has affected morale and retention within the Navy Medical Department and may well become an issue for the Navy and Marine Corps in general. Beneficiaries are frequently frustrated with the current state of Navy medicine. As you might imagine, it is extremely frustrating for a trained medical provider to be unable to perform simply because of a lack of resources.

The Navy has taken a number of steps to improve Navy medicine during the last two years. The FY-88/89 Navy Medical Plan, submitted to Congress in July 1987, sought congressional support (subsequently approved) for future medical end strength growth and a major peacetime contracting program which grew from zero in FY-87 to \$16.2M in FY-88 and \$88.7M in FY-89. For FY-90 we seek \$138.7M.

The Navy also recognized problems associated with the physician recruiting process. Remedies included streamlining the administrative processing of physician applications from over one year to less than 90 days, adding more recruiters, and increasing recruiting incentives for physician accessions. Our initial results are promising.

The Navy developed a long-range Medical Strategy in September 1987 to improve use of existing facilities through additional peacetime contracts, more NAVCARE clinics, and new Fleet Surgical Teams to minimize disruptions caused by operational needs. Despite a constrained fiscal environment Navy has made resource allocation decisions for FY-90 through FY-94 which allow significant progress in executing this strategy.

Another significant effort to attack medical personnel issues was the formation of a Medical Flag Level Steering Group to assess declining retention. This group recommended several compensation changes for nurses and physicians, some of which were addressed in the FY-89 Defense Appropriation Act. Others are under consideration.

While we still face serious problems, I am optimistic about our ability to solve them. The source of my optimism is the investment made by the line Navy and our Secretary. I am pleased to report that the Navy line leadership has taken on our problems with resolute determination to be a full partner in solving them. Admiral Edney, the Vice Chief of Naval Operations, has taken a hands-on approach to helping us solve our problems and has made it perfectly clear that a problem in Navy Medicine is his problem. The most immediate tangible result of this position is, that management talent at the highest levels throughout the Department of the Navy is being brought to bear on fixing Navy Medicine.

BLUE RIBBON PANEL

In May 1988 the Secretary of the Navy established a Department of the Navy Medical Blue Ribbon Panel (BRP) to recommend actions that would improve access to Navy hospitals and clinics for all beneficiaries, reduce the dependency on the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), and revitalize Graduate Medical Education. The objective was to achieve these results through better use of Navy hospitals and clinics, while providing the necessary capabilities to meet Navy and Marine Corps wartime medical requirements.

The Vice Chief of Naval Operations chaired the Blue Ribbon Panel. Other members of the Panel included the Assistant Secretary of the Navy (Manpower and Reserve Affairs), the Navy Surgeon General, a senior Marine Corps representative, and the most senior Navy line officers responsible for logistics, financial management, and manpower. The Panel also included a prominent civilian physician.

The Panel studied several important Navy Medical Department management issues including: (1) Organization and Management; (2) Clinical and Operational Medicine; (3) Manpower, Personnel and Training; (4) Contracting; (5) Budget Execution; and (6) Equipment Procurement and Maintenance. These task forces identified specific topics, formulated alternatives, and prepared final recommendations on 76 issues. Six general conclusions emerged from the findings of the Task Forces:

- o Navy medicine must focus on increasing its in-house capability through optimal use of existing Navy hospitals and clinics. This will not only reduce CHAMPUS costs but will also maintain wartime readiness.

- o Navy medicine must assign GME top priority. GME remains the foundation of the Navy healthcare system. It must receive first priority manning for Navy's top physicians and other providers. A full and vigorous GME program safeguards both peacetime and wartime capability.

- o Navy medicine must develop measures of effectiveness.

We have no truly effective means of measuring individual or system performance. We must implement approved criteria, establish a baseline, set annual goals, and track progress.

- o Budget realities preclude adding unlimited dollars and end strength. Navy must carefully consider initiatives to improve Navy medicine to ensure cost effective solutions. Budget constraints preclude attempting to solve the problem by simply adding additional resources.

- o We must document and communicate meaningful improvements in Navy medicine. This is needed to improve the perception of the Medical Department within the Navy and vigorously instill lost pride. The Department of the Navy must demonstrate to its Medical Department, sailors and marines, beneficiaries, and the Congress that visible changes can and will occur as a result of the Blue Ribbon Panel actions.

o Maintain the Blue Ribbon Panel and Flag Officer Working Group. While some Blue Ribbon Panel initiatives are already implemented, many will not reach fruition for a year or more. The Blue Ribbon Panel/Flag Officer Working Group will monitor the implementation of these initiatives pending subsequent review.

Some of these recommendations will require additional resources, money and people, to implement. We are investing in those initiatives that make good business sense; those which provide a reasonable return on investment. As the initiatives are implemented, the costs will be monitored and execution plans adjusted to implement as many initiatives as possible with the funds available.

Success of this effort, and the necessary improvements in Navy medical care, will require continued oversight to identify and solve medical problems. The Blue Ribbon Panel will monitor execution of these initiatives and address emergent issues.

The Blue Ribbon Panel has put in motion many actions which will improve access to Navy healthcare facilities, reduce Navy medical costs, and revitalize Graduate Medical Education. Some results have already been seen; others will take time to be realized. It must be recognized, however, that these are being done with only one goal in sight: to provide the best healthcare to all Navy beneficiaries.

We have already begun to implement prototype solutions based on many of these recommendations at the National Naval Medical Center, Bethesda, Maryland. The Medical Center is being made a center for excellence in Navy Medicine. As the management strategies we implement at the hospital prove successful they will be exported to our other hospitals. A Rapid Implementation Team composed of senior, tested, experienced medical and line officers is at work turning the situation at Bethesda around. They are eliminating the equipment purchase/lease backlog, hiring civilian personnel into vacant positions, and implementing contract nurse support at the hospital. Seven new records clerks have been

hired and automated laboratory support to the wards has been increased. These are all initiatives we hope to export to our other hospitals. A long range planning office has been established at the medical center to encourage institutionalization of these changes. Innovations that work at Bethesda or other Navy hospitals will be exported to the other treatment facilities through the Medical Command and the newly established Management Assistance Teams. The teams are available to Commanding Officers to help analyze and solve problems.

MEDICAL DEPARTMENT PERSONNEL

Our personnel strategy is really quite simple. We seek to have motivated people performing the tasks they are trained to perform. Physicians will see patients; nurses will provide nursing care and train our corps staff; corpsmen will support all aspects of Navy Medicine; professional managers will manage our daily activities, and all qualified senior officers will be challenged to take on the leadership responsibilities of command. To accomplish our goals we must first recruit, train, and retain quality people. We are not winning this battle.

ONBOARD PERSONNEL

	<u>FY88</u>	<u>FY89*</u>	<u>NET GAINS/LOSSES</u>
Medical Corps	3929	3882	- 47
Nurse Corps	3068	2955	-113
Dental Corps	1679	1675	- 4
Medical Svc Corps	2534	2534	0
Physician Ast.	238	232	- 8

* End of January 1989

While we have essentially held our own with the medical corps so far this year, the nurse shortage continues unabated.

We have had variable success with meeting our recruiting goals.

RECRUITING SUMMARY

	<u>FY88</u>		<u>FY89</u>	
	<u>GOAL</u>	<u>ATTAIN</u>	<u>GOAL</u>	<u>ATTAINED/PROJECTED</u>
MEDICAL	150	84	241	55/100-120
DENTAL	81	61	90	60/60
MEDICAL SVC	141	206	273	87/175-200
NURSE	376	235	416	88/250-300

The up side of this chart is that we will do a little better, overall, this year than we did last year. The down side is that it is not likely that we will meet the more challenging goals we set for this year. This is not for lack of trying. Medical recruiting positions have been increased from 30 to 93. We are developing plans to streamline the process for recruiting for physicians. Essentially, we will adopt much of the program the Navy now uses to recruit nuclear power officers--a sort of one stop shopping for medical officers. Additionally, we are increasing our residency training programs and the number of Health Professions Scholarships. These programs will help us continue to ramp-up in recruiting. This in turn will make the work environment more attractive and positively contribute to our retention goals.

MEDICAL OFFICER RETENTION BONUSES

The Navy is experiencing a well documented precipitous drop in retention of high quality, specialty trained physicians needed to meet the rapidly increasing demand for medical care from active duty, dependents, and retirees. The FY-89 Medical Officer Retention Bonus was developed as a stopgap measure to retain unobligated, specialty trained physicians until legislation for a new physician compensation plan designed to attract and retain physicians on active duty could be developed.

The Medical Officer Retention Bonus, developed by ASD(HA) provided the highest bonuses to medical specialties with the largest pay differential between military and civilian net income. Physicians in primary care specialties (Internal Medicine, Pediatrics, Psychiatry, Pathology, Neurology, Family Practice, Occupational and Preventive Medicine, Aerospace and Undersea Medicine) where differentials from the civilian sector are less, were to be offered a much smaller bonus in the widely publicized ASD(HA) plan. Subsequently, the Department of Defense removed the retention bonus for all of these primary care specialties; the physicians who, in large part, manage our patients' care from their initial visits to subsequent referral.

In reviewing the need for a new medical compensation plan for FY-90 and beyond, DOD is studying the 1980 legislation, current peacetime and wartime requirements, medical officer retention trends, compensation levels for civilian physicians, and environmental factors affecting military physicians decisions to stay with or leave their respective medical departments.

Several other very positive steps have been taken to improve our accession and retention of physicians. First, we have increased the number of health professional scholarships from 1175 to 1200. This will allow us to continue to be highly selective in choosing students. We will be recruiting from the top of the market. We also plan to award 15 Navy Reserve Officer Training Corps (ROTC) scholarships in addition to the 15 Naval Academy graduates we place in medical school. All of these programs in combination should help us reach our goal of increasing physician end strengths from 3929 to 4505 over the next five years.

THE NURSING SHORTAGE

The effects of the physician shortage are compounded by a shortage of registered nurses. Like our colleagues in the private sector and other federal health systems, we are having a very difficult time recruiting qualified nurses. Our problems are exacerbated by our inability to retain them. As with our physician professionals, we find that we must improve the way we compensate our nurses. We are looking at various ways to solve this problem--some of which involve innovative and competitive recruiting programs and some of which are common-sense measures.

We have developed or are developing several programs which will help us attract more nurses into the Navy. First, we have increased the age of accession to 40 for active component nurses and up to 47 for reserve component nurses. Hopefully, this will help us attract civilian nurses who already have the skills and expertise we need in our medical treatment facilities. These are both actions we wish to continue. Secondly, we are including nurses in ROTC. We are revitalizing the medical enlisted commissioning program, which has a proven track record of attracting, and then retaining, high achieving

corpsmen and dental technicians into the Navy nursing profession. We are also seriously considering adding a technical level of patient care provider to our present categories which brings associate degree nurses into our system. As you know, we have resisted recruiting into the Navy Nurse Corps any nurses who are not classified as "professional nurses", that is, registered nurses with baccalaureate degrees. I have concluded, and the Navy's nursing leadership agrees, that it is time to explore every possible alternative to our traditional approach. If very carefully managed, we might be able to achieve some real gains from a program which brings associate degree nurses into our system. The program must be designed to permit, encourage, and support these technical nurses to advance their careers through further education and through advancement in the Navy to full, commissioned status.

We are adding a new specialty for our corpsmen, the advanced care technician. The advanced care technician program will provide seasoned, qualified enlisted personnel advanced training in bedside patient care so they act as nurse extenders, providing nursing care expertise in most medical settings. Trained and supervised by nurses, the career track of these corpsmen will include progression, by further education, eventually to commissioning in the Navy Nurse Corps.

Another area of special concern is a situation which prevents us from taking full, and I think potentially substantial advantage, of the constructive service credit authority granted by Congress. Properly used, this authority would allow us to bring nurses into the Navy as lieutenants, or even lieutenant commanders. Unfortunately, we are effectively constrained in exploiting this authority by officer grade strength limitations.

THE ACCESS CHALLENGE

The manpower shortages and increasing support roles I have so far addressed affect our patients by decreasing their access to healthcare services in our facilities. This creates a serious challenge to the Navy to increase access to services without "busting the budget".

When we ask our people their views about the Navy healthcare system they respond in two ways. First, they say they much prefer to receive their care in Navy treatment facilities. Second, they tell us they can't get into the system--they don't have access to the care they seek. We have taken, and are continuing to take, a range of actions designed to significantly increase access to our system.

The NAVCARE clinics we initiated in 1987 remain a popular alternative to our own treatment facilities and help relieve the pressure on those facilities. In Fiscal Year 1988 we provided about 330,000 visits through these clinics at an average cost of about \$60.00. The average cost of the nearly one million visits budgeted for fiscal year 1990 is just over \$48.00. While there are no Navy uniforms working in these clinics, there are plenty of Navy families receiving care at them. Today there are ten active clinics, with Norfolk and San Diego each having two. These ten clinics are contractor owned and contractor operated. Beginning with the budget you are now reviewing, we plan to open contractor operated clinics in government owned facilities. These facilities will provide the same easy access and high quality services now provided in our contractor owned facilities, but, at a reduced cost to the government. The first of these will be located in Mayport, Florida.

We have also made progress using our contracting initiatives. Emergency room and ambulatory care service contracts have been established at 19 of our facilities. We are also contracting for other important primary care functions like obstetrics and gynecology services, family practice, internal medicine and pediatrics. These contract initiatives will provide an additional one million visits to our system, and free-up medical staff for other high workload areas.

Contracting has also given us some badly needed temporary relief from our nurse staffing problem. Fourteen nursing contracts have been awarded at several of our major hospitals. We have found that even though we may pay an individual contractor employee more than we might pay a sailor or civil servant to do the same job, we still save money by avoiding the costs we would otherwise incur in CHAMPUS. However, one of the biggest disadvantages of this type of contracting is that we have personnel performing the same functions being paid vastly different salaries. The paradox of contracting is that the solution becomes part of the problem. It is not at all unusual for a private firm with whom we have an active contract to recruit our physicians and nurses. Consider the following entreaty sent to one of our active duty physicians, Dr. Higgins, regarding a position at the Naval Hospital, Camp Lejeune, NC:

Forming nine-physician family practice group for military population. Net compensation will be a minimum of \$120,000 (base plus incentives). Physicians will cover weekday clinic hours from 7:30 A.M. to 4:00 P.M. NO WEEKEND OR EVENING CLINICS. [Emphasis included by advertiser]

Dr. Higgins was offered a similar position at the Naval Medical Clinic, Norfolk, Virginia. By the way Dr. Higgins is Rear Admiral Higgins, Medical Corps, U. S. Navy, the Medical Officer of the Marine Corps. When I checked this morning, he still worked with us.

Our pharmacies are among our more popular and expensive services, demanding an inordinate portion of our resources. We are looking closely at demand patterns to improve both service and efficiency.

At San Diego, the pharmacy is one of the specific areas where we have effected improvements. We will open a branch pharmacy at the Naval Station on May 1st. This will be far more convenient for our patients and significantly relieve the congestion in the parking lot at the main hospital. In addition, we have increased the use of the operating rooms; surgical procedures are up and CHAMPUS costs are down. Our overall inpatient census is up also. The hospital has an average occupancy of 441 beds--up from 350 a year ago; the goal is 450.

Several innovative concepts have been implemented at Portsmouth Naval Hospital. We are taking advantage of the partnership program which allows us to bring providers in house and reimburse them through CHAMPUS. We are also working on establishing external partnership arrangements under which uniformed physicians provide services, such as surgery, to military patients in civilian hospitals. The physicians' fees are not billed to CHAMPUS, our physicians hone their skills, and our patients receive appropriate, timely care.

Similar partnership arrangements have been made at the Naval Hospital, Charleston, South Carolina. Additionally, Charleston is the site for the Navy Catchment Area Management demonstration. Our plan is being considered by the Office of the Assistant Secretary of Defense (Health Affairs), and we are confident it will be approved. We plan to see our first patient under the umbrella of the demonstration project on 1 October 1989. I believe this project foretells the future of military medicine. Local problems, and opportunities, will be solved/exploited by a management team intimately familiar with the local situation and under the direction of the hospital Commanding Officer.

At Camp Lejeune, the Commander is saving about \$1 million in CHAMPUS costs through a variety of productivity enhancement initiatives. All staff meetings have been scheduled outside of patient care periods--making nearly 350 physician practice hours available for patient care. A well-baby clinic has been established and sees over 300 patients each week. A highly successful mental health service has been established. The new service avoids CHAMPUS costs, and provides badly needed mental health support services to Marine Corps families.

We are very excited about the model family practice hospital being set up at our hospital in Newport, Rhode Island. This is a real test of our ability to work with the private sector resources in our communities. The hospital will be the locus of outpatient and routine follow-up care for our patients. When they require hospitalization, they will be admitted, by Navy physicians, to what would otherwise be idle facilities at the civilian hospital in town. We think this makes a great deal of sense for all concerned.

MEDICAL READINESS

We have augmented our capacity to support the fleet with the development of Fleet Surgical Teams. Two teams have been assigned to each coast. When a team is not deployed it will be assigned to the hospitals in Portsmouth or San Diego. Each multidisciplinary team has 21 members. These teams relieve our hospitals of the burden of continually providing personnel for routine medical operational readiness support for planned deployments and removed one of our principal irritants, the need to pull people assigned to our hospitals and clinics to support routine deployments.

Our ability to support our combat forces medically in major conflicts or other crises rests in part on an appropriate inventory of deployable medical units (DEPMEDG). These units--the hospital ships and fleet hospitals--will give us the ability to provide medical support close to the site of conflict, the flexibility to tailor medical capabilities to mission requirements, and the responsiveness to provide medical care when and where it is needed. Strategically, they form the foundation on which our medical readiness and operational support is built and contribute in a very real sense to our overall defense posture.

The first of two highly sophisticated, state-of-the-art hospital ships, USNS Mercy (TAH-19), was delivered to the Navy in December, 1986. The second ship, USNS Comfort (TAH-20), was delivered in December, 1987.

The primary mission of the hospital ships is to have available a mobile, flexible, rapidly responsive afloat medical capability to provide acute medical and surgical care in support of amphibious and surface warfare task forces. The hospital ships can:

- o Receive by means of helicopter or small boat transfer (while anchored) patients suffering from wounds, diseases, or other trauma;
- o Provide onsite emergency and recuperative care to patients until they can be returned to duty or evacuated to fleet hospitals, overseas fixed medical facilities or to the Continental United States (CONUS) for further treatment;
- o Provide 12 operating rooms and 1,000 beds and associated medical support per ship (80 beds for intensive care, 20 beds for recovery, 400 beds for intermediate care, and 500 beds for minimum care); and,
- o Deploy within 5 days from issuance of sailing orders.

While awaiting the requirement for their service in an operationally related mission, the ships will be maintained in reduced operating status (ROS) in a CONUS port; USNS Mercy is berthed in Oakland, California and USNS Comfort is berthed at Baltimore, Maryland. While in ROS, the ships will be manned by a Military Sealift Command civilian crew and by a Navy cadre of medical and non-medical personnel; a total of 51 personnel. These personnel will become part of the staffs of each ship during periods of full operating status (FOS).

Within five days from issuance of sailing orders, the hospital ships can be fully ready for deployment. When in full operating status, the medical treatment facility will be manned with a staff of approximately 1200 personnel. These personnel will be transferred from shore-based commands, primarily Naval hospitals and dental clinics, to fill the billets when the treatment facility is activated.

The other major element of our deployable units is the fleet hospital. Nine of our fleet hospitals have reached initial operating capability. Four more will come on line this year giving us a total of 8000 beds ready for use. The first three fleet hospitals achieved initial operating capability (IOC) during FY 1987. Five additional hospitals reached IOC in FY 1988. Delivery of these facilities provides an additional 2500 deployable hospital beds.

Fleet hospitals will be prepositioned at or near the point of planned operations to help ensure quick activation. When prepositioned afloat, the hospitals will be placed aboard commercial vessels chartered by the Military Sealift Command. These vessels, used as floating warehouses, will deliver hospitals to designated ports when directed. Fleet hospitals positioned ashore will be warehoused in CONUS or overseas at specifically identified sites in host nations. Navy has aggressively pursued its host nation support program to establish firm agreements and dates for prepositioning fleet hospitals throughout the world.

The Defense Department's Fiscal Year 1990 budget request includes \$39.4 million in military construction funds to build fleet hospital storage facilities. We urge your support of this critical link in the program.

As DEPMEDS come on line, training of our personnel to man the platforms becomes an important priority. Fleet hospital operations training is presented at the Naval School of Health Sciences, San Diego Detachment, Camp Pendleton, California. This course is designed to teach fleet hospital staff members the principles of hospital assembly and operations in a combat environment. To reach initial operating capability (IOC) at least 40% of the hospital staff must be trained. The remaining staff will be trained as soon as possible after delivery of each hospital. To the extent that resources permit, we plan to provide refresher training every third year.

MEDICAL READINESS STRATEGIC PLAN

We continue to work with the Office of the Assistant Secretary of Defense (Health Affairs) and the other Services on implementing the Medical Readiness Strategic Plan. Several significant action plans have already been completed. These include professional association agreements, military medical skills training, graduate medical education, combat casualty care course expansion, and wartime medical equipment purchasing items. In all, nearly sixty percent of plan milestones and tasks had been completed by December, 1988.

HIGHLIGHTS OF THE FISCAL YEAR 1990 BUDGET REQUEST

The budget you are now reviewing requests resources which are vital to our efforts to improve the Navy healthcare system. We plan to continue to invest in our contracting initiatives so we can increase access for our patients and avoid the costs of CHAMPUS. We will begin rebuilding the Navy's physician assistant program with this budget. Funds are requested to support 140 additional physician assistants who will provide basic level primary care health services to our people thereby relieving physicians to perform more complex medical procedures. With the implementation of our Healthcare Finder Program we will stop the cruel practice of "disengaging" our patients and begin the traditional medical practice of referring our patients to known qualified medical professionals who have the skills our patients require when we can not provide those services. We will be hiring 118 additional medical technicians to help us improve the efficiency of operations of our laboratories so that we can get needed test results to our clinicians in less time.

To help us attract physicians we request funding to support an additional 150 medical scholarships, and to support Navy graduate medical education faculty development through outservice training. These fellowships will help us create a mix of faculty subspecialties to meet accreditation standards.

I would also add a thought about another item which appears in Defense Agency Military Construction rather than Navy's budget--the replacement of the Naval Hospital in Portsmouth Virginia. Our hospital at Portsmouth is badly in need of replacement. The project has been economically studied and space planned for minimum essential needs that will allow us to recapture CHAMPUS referrals, continue to train our physicians in this intense clinical environment and, primarily, replace a facility that is in serious need of replacement. I urge your support for this construction project.

CONCLUSIONS

Make no mistake about it, Navy Medicine was, and is, in a state of crisis--the solutions are complex and must be applied over the long haul with the focus of the entire Navy leadership team, the Congress, and the support of both our care providers and those provided for. There are no quick and no easy fixes.

That assessment by the Vice Chief of Naval Operations at a recent Naval Institute Seminar is one which I share.

We have set in motion the changes needed to fix our system for the long haul. The Navy line is fully committed to supporting us. The workload data strongly suggests that our patients are beginning to come back to us. We must have your continued support if we are to be successful. The budget proposal we are here defending requests only what we think we need to fix our system. I am committed to doing whatever is necessary to solve our long standing problems. The line Navy wants a medical support system they can once again put forward as a valuable benefit. The Navy and Marine Corps families that depend on us have been extremely patient and are beginning to benefit from increased access and the heightened morale of our providers. You and your colleagues have been very helpful. We are all grateful for that help. We now need your help with this budget.

Thank you again for your support and I look forward to working with you over the coming year.

BIOGRAPHICAL SKETCH

Vice Admiral James A. Zimble is the 30th Surgeon General of the Navy and Director, Naval Medicine.

Admiral Zimble was born October 12, 1933, in Philadelphia, PA. After spending his formative years in Little Rock, AR and Bala-Cynwyd, PA, he graduated from Franklin and Marshall College, Lancaster, PA, with a Bachelor of Science Degree and received his Medical Degree from the University of Pennsylvania School of Medicine in 1959. He served in the Naval Reserve as a medical student from 1955 to 1959.

After serving a rotating internship at the U.S. Naval Hospital, St. Albans, NY, from 1959 to 1960, Admiral Zimble attended the Deep Sea Diving School, Naval Gun Factory, Washington, DC; the Officer's Basic Course and Special Radiation Control and Health Physics Course, U.S. Naval Submarine School, New London, CT; and nuclear power training at the Nuclear Reactor Prototype, West Milton, NY.

Admiral Zimble was subsequently assigned to the USS JOHN MARSHALL (SSBN-611) as the plank owner medical officer of the Blue Crew. In 1963 he received Submarine Medical Qualification. Follow-on assignments included: OB-GYN staff, Naval Hospital, Camp Pendleton, CA (1966-1970); OB-GYN staff, Naval Hospital, Philadelphia, PA (1970-1972); Chief, OB-GYN Service and Director, Clinical Services, Naval Hospital, Lemoore, CA (1972-1976); Director, Clinical Services, Naval Regional Medical Center, Long Beach, CA (1976-1978); Commanding Officer, Naval Regional Medical Center, Orlando, FL (1978-1981); The Medical Officer, U.S. Marine Corps (1981-1983); Fleet Surgeon, Commander in Chief, U.S. Atlantic Fleet, with additional duty as Command Surgeon, U.S. Atlantic Command and Medical Advisor to Supreme Allied command, Atlantic (1983-1986). In February, 1986 he reported to the Office of the Assistant Secretary of Defense (Health Affairs) as Deputy Assistant Secretary of Defense (Strategic Planning and Medical Program Management). He was promoted to the rank of Vice Admiral and assumed the duties as Surgeon General of the Navy and Director, Naval Medicine on 1 July 1987.

Admiral Zimble completed his residency training in Obstetrics and Gynecology at the U.S. Naval Hospital St. Albans, NY, in 1966. He is a Diplomate of the American Board of Obstetrics and Gynecology, a Fellow of the American College of Obstetrics and Gynecology, a member of the American Medical Association, the Association of Military Surgeons of the United States and the Inter-Agency Institute for Federal Health Care Executives.

His military decorations include the Defense Superior Service Medal, Legion of Merit (three awards), the Defense Meritorious Service Medal, the Meritorious Service Medal, the Navy Commendation Medal, and the Navy Meritorious Unit Citation.

Admiral Zimble is married to the former Janet Bailey of Westfield, NJ. They have two sons and four daughters.

STATEMENT OF LT. GEN. MONTE B. MILLER, THE SURGEON GENERAL, U.S. AIR FORCE

Senator INOUE. General Miller.

General MILLER. Thank you, Mr. Chairman. It is a pleasure to be here today and discuss very briefly Air Force health care services.

I am privileged to lead an organization of over 55,000 top-notch professionals who operate a comprehensive health care system, and we serve over 3 million patients throughout the world.

INTEGRATED MISSION

I am often asked, and that subject was discussed earlier, about how do we balance the peacetime and wartime requirements, and the response is simply that we have an integrated mission. Our work is as crucial today as it would be in wartime and certainly adds to deterrence, which is the whole secret of the readiness posture as far as the medical world is concerned.

We practice our wartime skills every day by providing care to our patients. There has been progress and that progress has been noted. There are continuing concerns in medical readiness, certain-

ly in improving accessibility to health care services. There are concerns over retention and construction programs.

I would like to allude for just a few seconds to the excellent quality of Air Force health care, the financial outlook, and health promotion. Medical readiness continues to be my first priority. Our capabilities to do our job in wartime are greatly improved, but we must continue to increase and modernize these capabilities.

It is my belief that it was the intent of the Congress to help our medical readiness programs by requiring the targeting of some 2,500 health professions scholarships to students in the final 2 years of medical school who would accept residency training in the so-called critically short specialties in wartime.

GRADUATE STUDENT PROGRAM

There are some difficulties with this unfortunately. As an alternative, the Department of Defense developed a legislative initiative to better achieve, we think, the congressional intent. It would establish a graduate student program targeted toward physicians in the last 2 years of their specialty programs, their residency programs. Those sponsored residents have both an Active and a Reserve duty obligation.

This concept could achieve the desired results of reducing both Active and Reserve component specialty shortfalls much earlier, and we think with a far greater degree of assurance.

SHARING AGREEMENT

My greatest challenge today as far as providing Air Force health care right now is making quality care more accessible to our patients. We have introduced a number of improvements, including sharing agreements with the VA, which have been discussed. And may I add parenthetically that it is our view, and I think shared by my colleagues at the table, that the success of these programs has been that we have allowed those arrangements and those agreements to be negotiated at the local level.

We do not foresee a need for another layer of bureaucracy to impose those agreements. In Air Force we have over 200 such agreements. Every Air Force hospital with a VA medical facility within a 50-mile radius has at least some form of a sharing agreement, whether it is sharing lab tests or the example of Kirkland Hospital which you heard.

We are working the partnership programs with civilian providers, and you have heard the problem that creates as far as sometimes not as well trained a specialist working in an office next to one of our blue suit specialists, who is making three times as much money. And that is a disincentive in itself.

We are making some progress in the opening of Air Force PRIMUS clinics, and I think that you and the committee know that this has been a success story, although we have concerns again that we cannot deploy those contractors. Neither are they under our eyesight and direct line of vision so that we can control the quality as well as we would like. And it is more expensive than care in the direct care system.

We believe that the future hope of improving accessibility and controlling costs is basically through locally managed health care, the catchment area management demonstration which has been approved and which are ongoing.

It strikes us as a terrible dilemma that, although we do not have the personnel we need for our wartime readiness posture and yet CHAMPUS costs twice as much, 1.9 times, what it costs to provide care in the direct care system, that we cannot maximize, because of limited resources, our ability to provide that care in the direct care system, which provides us daily training.

RETENTION SPECIAL CONCERN

Retention of critically needed specialists, of course, is a special concern and has been addressed by my colleagues. We continue to experience significant problems in certain specialties. And the temporary measure, the medical officer retention bonus [MORB] for this year, was supposed to be a temporary measure.

You have already heard that it did not target over 50 percent of those who provide primary care, and that is a major concern to us, and we welcome your concerns that perhaps that should be re-studied.

Air Force is a long way from reaching its fiscal year 1989 recruiting goal of nurses, and you heard that from my colleagues as well. That is a focal area of major concern.

We continue to be focusing on the quality of Air Force medicine. Our goal certainly is to maintain and enhance the quality of Air Force health care through aggressive quality assurance programs and by recruiting and retaining those top-notch professionals. Quality care is certainly dependent on quality people with quality training.

We have been able to recruit most of our physicians from the top 25 percent of their medical school classes. Of Air Force physicians, 75 percent are specialty board certified, versus 55 percent in the civilian sector. Air Force-trained physicians taking national board examinations in their specialty consistently place well above the national average, and several of our training programs are nationally ranked.

This year the Air Force Medical Service celebrates its 40th anniversary. We have grown and prospered because of the talent, persistence, and commitment to the pursuit of excellence by our people and by the support of this committee in no small measure.

Today military medicine faces many challenges, but our dedication to the health care needs of the military family has not changed. We will continue to improve our readiness posture and to work hard to provide the best in health care services.

But our continued success depends on money, materiel, and manpower. With your support and understanding, we will meet our objectives.

It is a pleasure to be able to present these views to you, sir.

[The statement follows:]

STATEMENT OF LT. GEN. MONTE B. MILLER

Mr. Chairman and members of the committee, It is my pleasure to be here today to discuss Air Force health care services. I am privileged to lead an organization of more than 55,000 top-notch professionals who operate a comprehensive community health care system providing services to over three million people throughout the world.

I'm often asked, "How do you balance peacetime and wartime requirements?" My response is that we have an integrated mission. Our work is as crucial today as it would be in wartime. We practice our wartime skills every day by providing care to patients. However, if we should be deployed, everyone in the Air Force Medical Service would have a job to do.

Today I want to discuss our progress in medical readiness and in improving accessibility to health care services, my retention concerns, our construction program, the excellent quality of Air Force health care, the financial outlook, and health promotion.

Medical Readiness

Medical readiness continues to be my first priority. Our Medical Service remains committed to the deterrence of war through operational support of our fighting forces. Optimum combat medical support depends on peacetime readiness for wartime effectiveness. To prepare for the treatment of the sick and injured during wartime, we operate a comprehensive health care system in peacetime to ensure that our medical response for wartime is ready and rapid.

Prepositioning war reserve materiel (WRM) assets overseas is a major component of our readiness program. By prepositioning contingency hospitals and other collateral assets, we will have medical facilities available to treat and evacuate casualties. Additionally, we will conserve critical airlift resources for the movement of other items required to support combat operations.

We now have an initial operating capability at Kimhae Air Base, Republic of Korea, with a pre-engineered metal building configured to store and operate a 500-bed contingency hospital, a 250-bed aeromedical staging facility, and a blood transshipment center. This hospital will be the major U.S. Air Force contingency facility available to care for casualties on the Korean peninsula.

Throughout the continent and the United Kingdom, we now have fourteen 500 bed contingency hospitals, 6 blood transshipment centers, 13 aeromedical staging facilities ranging from 50 to 250 beds and 37 second echelon facilities in place.

Aeromedical evacuation operations will improve during wartime with a segment of the Civil Reserve Air Fleet (CRAF) dedicated to medical operations. This will provide a much needed increase in strategic aeromedical evacuation capability. In addition, we have developed a new system, CRAF Aeromedical Evacuation Shipsets, that reconfigures civilian aircraft without modification within 12 hours.

This summer we begin training our medical readiness units to use the SCPS-M -- Survivable Collective Protective System-Medical -- a blast hardened, chemically-protected medical treatment facility that will be buried underground at overseas air bases to provide second-echelon care to combat casualties.

We are about to embark on the most ambitious field medical readiness training program in Air Force history. Phase III of our Medical Red Flag Program will begin operation next fiscal year and will train personnel assigned to deployable medical units in our new prepositioned medical assets and our SCPS-M shelter. We hope to cycle every active duty medic who is on mobility through this training every three years.

As a complement to Medical Red Flag, the Medical Readiness Training Site at Phelps-Collins ANG Base, Michigan, will conduct all second-echelon training for deployable Air National Guard (ANG) and Air Force Reserve (AFRES) medical units.

The Reserve and the Guard together comprise the Air Reserve Components. They make a significant contribution in both peacetime and wartime. Currently, these elements of the Total Force are tasked to provide 35 percent of the wartime medical manpower requirement. Together the Reserve Forces comprise 70 percent of our second echelon tasking, 75 percent of our CONUS augmentation tasking, and 97 percent of our aeromedical evacuation wartime capability.

Our capabilities to do our job in wartime are greatly improved. However, we must continue to increase and modernize our medical capabilities through research and development programs. Things to look for in the future include an Improved chemical/biological protective garment, a Multi-Chambered Auto Injector for nerve agent pretreatment and antidote, a nerve agent anti-convulsant auto injector, Transportable Blood Transshipment Centers, a Resuscitative Fluids Device, a Digital Imagery System, and many more.

Our graduate medical education programs will continue to produce the maximum number of specialists with critically-needed skills. Incentive programs including loan repayment and education and training stipends have been implemented for the Air Reserve Components, and our recruiting energies are targeted to accessing people who have these critically-needed skills.

I believe it was the intent of Congress to help our medical readiness program by requiring the targeting of 2500 Health Professions Scholarships to students in the final two years of medical school who accept residency training in a critically-needed wartime specialty. Unfortunately, there are significant difficulties with this. First, students entering their third year of medical school are usually unsure of their residency preferences, and these may change often before the medical student becomes a trained specialist. Second, the competition for residency positions is so fierce that it is impossible to guarantee entry into the desired residency. Third, even if the student does manage eventually to gain acceptance in a residency in a critically-needed specialty, he or she may not ultimately complete the training for a variety of reasons.

As an alternative, DOD is considering a legislative initiative to better achieve Congressional intent. The proposal would establish a Graduate Student Program targeted toward physicians in their last two years of residency in critically-needed specialties. Sponsored residents would have both an active duty and a reserve duty obligation. This concept could achieve the desired results of reducing both active and reserve component specialty shortfalls much earlier and with a far greater degree of assurance.

Improving Accessibility

The greatest challenge facing Air Force health care right now is making quality care more accessible to our patients. We have introduced a number of improvements including sharing agreements with the VA, partnership programs with civilian providers, and the opening of the first Air Force PRIMUS clinics. Our greatest hope for improving accessibility is through locally managed health care.

We are striving toward fully managed health care. That means providing or arranging for the appropriate level of care in a timely, cost effective manner that meets our standard of quality. We think catchment area management is the answer. Since health care has always been a local issue, we feel it is best managed locally where the experience and local contacts are established. We have two demonstration projects starting this fiscal year - Bergstrom AFB, in Austin, Texas, and Luke and Williams Air Force Bases in the Phoenix, Arizona, area. The demonstrations will run for a minimum of three years.

We are currently phasing in the management and baseline activities. This project will place the responsibility of health care provision upon the local Air Force medical facility executive management team who will have control of capitation funding, including CHAMPUS dollars. The Air Force catchment area management system will incorporate an enrollment process, a health care finder function, a utilization management program, a claims processing system, and an automated data system to provide integrated support for all functions. Our long range plan is to transition to catchment area management at all Air Force medical treatment facilities as the logical progression of our current Health Care Finder program.

While catchment area management is not yet underway, we have some excellent programs in full swing that support catchment area management. Our Health Care Finder program has been very successful. It's improving access to health care and reducing patient and government costs while maintaining our stringent quality. We now have approximately 17,000 civilian providers involved in this program Air Force-wide.

The Partnership Program is another resource for improving patient access to needed health care services. We have 300 Partnership agreements Air Force-wide, including psychiatry, obstetrics, and cardiology. With some ingenuity, Partnership Programs can offer a realm of possibilities at the local level. VA sharing agreements offer another. More than 50 percent of Air Force medical treatment facilities located within a 50-mile radius of a VA medical facility have sharing agreements with the VA. There are currently 53 Air Force hospitals with a total of more than 200 active agreements. They include sharing a wide variety of resources ranging from facilities to individual clinical and ancillary support services. We have a joint facility established at Kirtland AFB, New Mexico, and are planning other sites at Nellis AFB, Nevada; Elmendorf AFB, Alaska; and Patrick AFB, Florida. This program works well, providing a wider range of services for both Air Force and VA patients than would otherwise be the case, in addition to saving money. I would like to see this program expand to include CHAMPUS-eligible patients which would offer them better access to health care at a lower cost than under the CHAMPUS program.

We just opened our first three PRIMUS clinics. The locations are Omaha, Nebraska, to support Offutt AFB; Tucson, Arizona, to support Davis-Monthan AFB; and Riverside, California, to support March AFB. Two more are scheduled to open this fiscal year at Sacramento, California to support Mather AFB and at Tampa, Florida to support MacDill AFB. These clinics

will improve patient access to primary medical services at selected locations where demand far exceeds current capability. These clinics, while helpful in the near term, are not the ultimate solution to our access problems. We would prefer to provide care to all our patients via the direct care system.

Our patient population is estimated at 3.4 million and is continuing to grow. In FY 88, our facilities treated more than 18 million outpatients, and nearly 270,000 patients were admitted. Nearly 35,000 babies were born, and more than 33 million prescriptions were filled in our facilities. There were no discernable shifts in the distribution of health care for our eligible beneficiaries from FY 85 to FY 88. However, we have noticed a steady reduction in the number of admissions to Air Force hospitals from 275,100 in FY 86 to 269,800 in FY 88. This reduction is consistent with civilian hospital trends over the past decade and is largely the result of rapidly emerging technology permitting more treatment to be performed on an ambulatory basis. This has not diminished the demand for health care but rather has shifted it from the inpatient to the outpatient setting. It underscores our urgent need to find new ways of increasing patient accessibility.

This shift has presented some problems since our older medical treatment facilities were not designed to meet today's growing demand for care. We are now reshaping our hospitals from a predominantly inpatient to an ambulatory care orientation. Our goal is to meet existing patient demands for care and to recapture the outpatient workload now provided under CHAMPUS. The first step, taken in September 1988, to achieve this was the trial establishment of a single ambulatory services manager for our hospitals. We are also evaluating support staff and examination room-to-practitioner ratios based upon civilian norms and Air Force wartime requirements. The goal is to establish the proper mix of exam rooms, support staff, and practitioners to achieve peak efficiency in ambulatory services. To reach this goal will require nearly 260 new authorizations for the Medical Corps, 290 more for the Nurse Corps, and 760 additional enlisted spaces.

The Exceptional Family Member Program provides medical care and medically related services for eligible DOD families with exceptional medical or educational needs. The Air Force has responsibility for all medically related services in the Philippines, the United Kingdom, the North Atlantic region, the entire Mediterranean, and the Wiesbaden area of West Germany. We are providing as much service for these family members as our current resources will permit.

Retention Concerns

Retention of critically-needed specialists is a special concern. While overall retention was stable in FY 88, we continue to experience problems in certain specialties. Although the Medical Officer Retention Bonus (MORB) is supposed to be a temporary measure until a permanent revision to the special pay law is enacted, approximately 50% of eligible Air Force specialists are not included in the implementation of this bonus. Their perception is that they are less valued and less vital to our mission. Nothing could be further from the truth. Primary care specialties are the foundation of the referral structure of our medical care system. They are key to the success of our graduate medical education programs, to the reduction of CHAMPUS expenditures, and to the improvement of patient satisfaction. Their exclusion from the MORB may demoralize them and force them out of military service -- a result exactly opposite from the MORB's purpose. In addition, the degree of stratification of pay of

the MORB is in contrast to the Resource-Based Relative Value Scale. This Congressionally commissioned study is likely to become the basis of physician compensation in other federally funded medical services such as Medicare.

Most of our physicians recognize that a revised pay system such as that proposed in DOD's December 1, 1988, report to Congress must have a component of pay which varies by specialty.

We feel strongly that officers with training obligations not be paid less than their colleagues with equal training or experience. This was true in the 1970's and was a tremendous problem. Congress recognized this and eliminated this inequity in the current physician pay system. Another point of concern is how the MORB obligation will be treated in the new pay structure. We support the DOD position that MORB obligations be cancelled in favor of the proposed specialty-based pay system as long as the recipients obligate themselves for at least the same period under the new pay plan. This formula will be widely accepted by our physicians, especially those who are still debating whether or not to accept the MORB.

Non-compensation factors are also vital to an effective retention system. Initiatives to improve clinical and administrative support will be extremely effective in increasing productivity and reducing CHAMPUS expenditures. However, I cannot emphasize strongly enough that such initiatives will be ineffective unless they are used to supplement a satisfactory compensation system.

I am also concerned about nurse recruiting and retention. The Air Force is a long way from reaching its FY 89 recruiting goal of 613 nurses. We need to recruit 15 nurse anesthetists this year; so far, none have been commissioned. I anticipate a shortage of 31 nurse anesthetists through FY 90. We must also attract 14 nurse midwives. Right now, only one has consented to join.

Nurse retention is influenced by several factors including promotion potential and incentive pay.

We are facing more and more competition from civilian agencies. Some civilian institutions are contracting nurses in their last year of training and paying education costs. We need similar programs to maintain the attractiveness of military nursing in the marketplace.

Several years ago, the Air Force was directed to convert 98 military dental officer authorizations to civilian contract dentists during Fiscal Years 1987-89. The military positions were then converted to Nurse Corps authorizations to help meet the wartime shortage of nurses. At the time, there was no validation of the number of military dentists needed in wartime. We are now close to being able to validate wartime dental requirements. As suspected there is a shortfall when compared to our current force including the Air Reserve component.

Contracting difficulties have precluded us from filling all 98 positions with contract dentists. We estimate that, just since the beginning of this fiscal year, approximately 26,000 patient appointments have been lost because of our existing shortage of dentists. Contracting for these positions isn't working well in peacetime and does not serve us well in wartime. I believe these contract positions should be converted back to military authorizations.

We plan to resume training physician assistants in FY 90. While the force had been fairly stable for several years, the retirement of senior PAs is leaving a significant void which the recruiting system has not been able to fill. We will select experienced enlisted medical technicians for our training program and will train twenty-four students in each of three classes per year. The first graduates will join the workforce as commissioned officers in FY 92.

The University of Texas Health Science Center in San Antonio will begin a program to award a Master of Science in Nursing degree in Nurse Anesthesia. Twenty Air Force nurses will enter the first class in September 1989. The two-year program will include on-campus academic training as well as clinical practice at selected Air Force medical facilities. Already established is a master's degree program in Nurse Midwifery at Georgetown University. Under the auspices of the Nurse Midwifery Program at Malcolm Grow USAF Medical Center, Andrews AFB, Maryland, this affiliation with Georgetown offers selected midwives a unique, top-quality training experience.

Medical Construction

In January 1986, the Secretary of Defense established the Defense Medical Facilities Office (DMFO) under the Assistant Secretary of Defense (Health Affairs) with the responsibility for planning, programming, and allocating funds appropriated for all DOD medical readiness construction projects.

The DMFO's FY 89 Medical Military Construction Program (MCP) included 14 projects for Air Force medical facilities. Four of these projects were specifically in support of medical war readiness materiel (WRM) storage and prepositioning. All four of these projects were supported by the Congress and have a total value of \$15.3 million. One of the projects will provide a turn-key, 500-bed, third echelon medical contingency complex at a classified location. Two of the projects will provide warehouse facilities for prepositioning second echelon medical equipment and supplies in Europe. The fourth project will provide a medical WRM warehouse at Tyndall AFB, Florida.

The DMFO's FY 90 Medical Military Construction Program includes eight projects for the Air Force Medical Service with a combined value of \$100.8 million. Within the CONUS there is one project dedicated toward meeting compliance requirements. This is the life safety upgrade project programmed for the hospital at Maxwell AFB, Alabama. Additional proposed peacetime construction in the FY 90 program includes: the Air Force/Veterans Administration joint venture hospital at Nellis AFB, Nevada; two clinic addition/alteration projects at Andrews AFB, Maryland, and Lackland AFB, Texas; a clinic/dental clinic replacement at Hurlburt Field, Florida; and a dental clinic replacement at Patrick AFB, Florida.

The FY 90 program also contains readiness and overseas requirements directly contributing to the combat effectiveness of deployed forces. Two projects worth \$19.6 million support WRM requirements. A turn-key, 1000-bed, third echelon medical contingency complex at Echternach, Luxembourg, will enhance our ability to provide life-saving, surgically-intensive medical care to Air Force casualties which are expected to peak during the first days of a European conflict. This project was deferred by the Congress from the FY 88 construction program based on the belief that such a project should be financed through the commonly-funded NATO infrastructure program. Although this contingency facility may treat Allied casualties, it will primarily serve U.S. Forces. The other project

will provide for the prepositioning of second echelon medical equipment and supplies in the European theater.

Continued funding for facility construction and renovation programs is essential in our efforts to improve patient access to care and reduce growing CHAMPUS expenditures. We remain committed to a strong construction program and are working with the DMFO to correct longstanding construction deficiencies.

Quality Assurance

Another focal area is the quality of Air Force medicine. Our goal is to maintain and enhance the quality of Air Force health care through our aggressive Quality Assurance programs and by recruiting and retaining top-notch health care professionals. For instance, the DOD Civilian Peer Review program, which has no comparable civilian counterpart, has found unresolved differences in a remarkably low number of cases. As a further example, Obstetrics is the nation's highest malpractice risk, high volume medical specialty; yet a two-year study found that Air Force obstetrical services met or exceeded U.S. civilian sector norms in all 17 categories measured. In addition, all Air Force hospitals seeking accreditation from the Joint Commission of Accreditation of Healthcare Organizations have been accredited. In comparison, two percent of civilian hospitals fail to achieve accreditation.

Quality care is dependent on quality people with quality training. We have been able to recruit most of our physicians from the top 25 percent of their medical school classes. Seventy-five percent of Air Force physicians are board certified versus 55 percent in the civilian sector. Air Force-trained physician specialists taking national board examinations placed well above the national average, and several of our training programs are nationally ranked.

We are in the process of expanding the focus of our QA program to include not only physicians but also the many other factors, both clinical and administrative, that affect the quality of care. A review of FY 88 data shows a downward trend in Air Force malpractice claims -- 9.5 claims per 100 physicians -- that is well below the national average. In 1988, incidents resulting in malpractice claims have been reduced 17 percent from the peak in 1985.

We continue to plan the future of our Quality Assurance program. We are working hard to improve the substance, yet reduce the volume, of paperwork required for Quality Assurance administration. There is a clear and continuing need for documentation to ensure the validity and credibility of the quality of care. Yet we need to balance our administrative requirements with the primary duty of doctors and nurses to care for patients. We need the expertise of these providers in designing, monitoring, and evaluating indicators and in making peer review decisions. Additional administrative support - trained personnel and equipment - would allow us to make more efficient use of our providers' time, while enhancing the effectiveness of our Quality Assurance program.

We can measure the quality of care we provide, but we are also interested in how our patients gauge that care. This past year, of approximately 23,000 survey respondents, 85 percent were satisfied with the care they received in our medical treatment facilities. Patients identified "patient concern" as their most important consideration and the factor they found most satisfying.

Financial Outlook

FY 88 was a very lean year for us. While FY 89 has thus far been an improvement, we still face a \$100 million shortfall in the CHAMPUS program. Reducing CHAMPUS costs is a special challenge, but the recently approved CHAMPUS Alternate Use program will help expand services at selected bases. The initial group of candidate projects, some already approved for implementation, show a rate of return of approximately 1.7 to 1 (or \$1.70 for each \$1 invested) for the fully matured project by FY 91. Over the long term however, a more realistic expectation would be a rate of return of 1.5 to 1 as a full range of possible projects are explored and developed. This is another opportunity to prove that the local executive management team can manage the system better if given the resources.

Health Promotion

Through our Health Promotion Program, we continue to emphasize preventive medicine to promote healthier lifestyles, improve overall health, and enhance combat readiness. This past year, a health promotion prototype clinic opened at Carswell AFB, Texas, and promises to provide valuable insight for establishing wellness clinics throughout the Air Force. Over 900 individuals have been screened and half of this group is receiving intervention to assist with modifying unhealthy lifestyle behavior. The test is anticipated to be completed in late 1989.

The Air Force Anti-Smoking Initiative continues to decrease the number of active duty smokers. The latest Air Force smoking survey finds a 10.5 percent decrease in the number of smokers over the past year. The net result of our two-year anti-smoking campaign means 67,500 fewer smokers in the Air Force. Many medical treatment facilities have also adopted a smoke-free policy for staff and patients.

Another health promotion effort is our Coronary Artery Risk Evaluation (CARE) program, which was recently expanded to include a pediatric screening program known as CARE II. This program uses blood studies, blood pressure, weight, and family history to identify children who are at increased risk for developing coronary artery disease. The children then enter intervention programs and are tracked accordingly. We also counsel parents on the impact of factors such as nutrition, exercise, drugs, smoking, and alcohol.

The CARE Programs will soon be enhanced by automation. A base-level system that will automatically compute patients' coronary artery risk indices and provide tailored risk reduction actions is currently in software development. The base-level information will then be fed into a centralized computer for use as a research and trend analysis data base.

Contracting

We have established a Specialized Medical Contracting Activity within the Medical Logistics Division at Brooks AFB, Texas, to provide responsive support and advice on all matters related to contracting. This activity is directly responsible for developing, soliciting, and awarding services contracts that are required by multiple locations with similar needs or that lend themselves to central procurement.

This Activity has been successful in handling a number of contracts including those involving PRIMUS clinics and the Hospital Aseptic Management System. It is currently working on a requirements contract for radiologists as well as a centralized procurement for obstetrics and

gynecology services. All contracting endeavors will have the patient's best interest in mind.

Personal services contracts for certain specialties are very difficult to execute. The compensation limitation for direct health care provider personal services contracts is non-competitive in those specialties where industry standards dictate higher compensation. We need legislative relief to eliminate this compensation limitation. Contract costs will still be controlled through the competitive process established by the Competition in Contracting Act.

Conclusion

This year the Air Force Medical Service celebrates its 40th anniversary. We have grown and prospered because of the talent, persistence, and commitment to the pursuit of excellence by our people. Today, military medicine faces many challenges, but our dedication to the health care needs of the military family has not changed. We will continue to improve our readiness posture and to work hard to provide the best in health care services. Yet our continued success depends on adequate resources - money, materiel, and manpower. With your support and understanding we will meet our objectives. I will be happy to answer any questions you may have.

Biographical Sketch

Lieutenant General (Dr.) Monte B. Miller is surgeon general, Headquarters U.S. Air Force, Washington, D.C.

General Miller was born Sept. 4, 1930, in Independence, Mo., where he graduated from William Chrisman High School in 1948. He received a bachelor of arts degree with a major in chemistry from the University of Kansas in 1951 and was selected to the Phi Beta Kappa honorary scholastic fraternity. He continued his education at the University of Kansas School of Medicine and received his doctor of medicine degree in 1955. General Miller completed his medical internship at Tacoma (Wash.) General Hospital in 1956. He completed his residency training in internal medicine at Wilford Hall USAF Medical Center, Lackland Air Force Base, Texas, in 1965. He was specialty board certified in 1967 and recertified in 1977 by the American Board of Internal Medicine. General Miller was appointed assistant clinical professor at the University of California School of Medicine in 1968 and was elected to a fellowship in the American College of Physicians in 1972.

After receiving his commission as a first lieutenant in October 1956, he was assigned to the USAF Hospital, Williams Air Force Base, Ariz. He completed the Aerospace Medicine Primary Course at the School of Aerospace Medicine, Randolph Air Force Base, Texas, and received an aeronautical rating of flight surgeon in 1957. From October 1958 to July 1962, General Miller was engaged in private medical practice in Garnett, Kan. He re-entered the Air Force with an assignment at Wilford Hall for specialty training in internal medicine. In July 1965, he was appointed assistant for medical training at David Grant USAF Medical Center, Travis Air Force Base, Calif. From July 1967 to July 1968 he was assigned to the 12th U.S. Air Force Hospital, Cam Ranh Bay Air Base, Republic of Vietnam, as chief of medicine.

General Miller returned to David Grant USAF Medical Center as chairman of the Department of Medicine. He became deputy commander and director of hospital services in July 1973, and commander in May 1975. He was a key participant in the prisoners of war homecoming from North Vietnam, and Operation Babylift.

General Miller transferred to the Medical Directorate, Air Force Inspection and Safety Center, Norton Air Force Base, Calif., as an inspection team chief in July 1978. He then served as chief of the Medical Inspection Division from March 1979 to February 1980. In March 1980 he assumed command of Malcolm Grow USAF Medical Center, Andrews Air Force Base, Md. In November 1981 General Miller became command surgeon, Military Airlift Command, Scott Air Force Base, Ill.

In April 1985 General Miller became commander of Wilford Hall USAF Medical Center. He became command surgeon, U.S. European Command, Stuttgart-Valhingen, West Germany, in May 1986. He assumed his present duties in August 1988.

The general is a chief flight surgeon. His military decorations and awards include the Distinguished Service Medal, Defense Superior Service Medal, Legion of Merit

with one oak leaf cluster, Bronze Star Medal, Air Medal and Air Force Commendation Medal. He is a senior member and past president of the Society of Air Force Physicians, a member of the Kansas Medical Society and a fellow of the American College of Physicians. He is also a member of the Society of Medical Consultants to the Armed Forces, American Medical Association, Aerospace Medical Association and Association of Military Surgeons of the United States.

He was promoted to lieutenant general Aug. 1, 1988, with same date of rank.

General Miller is married to the former "Chris" Faye Vielguth of Burlington, Kan. They have two sons, Mark and Mitchell, and a daughter, Michelle.

PREVENTATIVE MEDICINE

Senator INOUE. Thank you very much, General.

About 5 years ago I read a report in which it stated that this Nation spends approximately \$1,500 per person, man, woman, and child, for curative medicine and about 50 cents per person, man, woman, and child, for preventative medicine. And all of the experts suggested that if we could increase that 50 cents to 75 cents, we could bring down the cost of curative medicine dramatically.

About the same time, the Surgeon General of the United States issued a rather famous report in which he cited the 10 major causes of death. And of that 10, I believe most could be prevented. You have diet, smoking, exercise, all of that.

I realize that in the Army you have control, or the Navy or the Air Force, control over the diet of the men, at least in the mess-halls. Beside that, what sort of preventative medicine do you practice in the services?

General MILLER. Most or all of us have full-time, or at least part-time, dedicated health promotion people now in all our facilities, and those are very active and vigorous programs.

You have heard discussed the success in cutting down smoking. We are also having success in treating alcohol folks. And those promotion programs vary from instruction in how to lift so that we do not have back injuries to what is a proper diet. And the dining halls are identifying what is healthy heart foods. We are working cholesterol reduction programs very aggressively.

We are working, as you know, the sexually transmitted disease issues very hard. And there is at least early indications of success, if incidence of AIDS is any measure.

It needs to be recognized, in my opinion, Mr. Chairman, that preventative medicine has long been a strong suit of our Armed Forces, and our noneffective rates as calculated have continued to decline.

It strikes me as being unusual that there are those that would place a barrier to that kind of preventative medicine by imposition of a user's fee. I would point out that the detection of meningitis in a young child and the prevention of having a mentally retarded kid to take care of for the rest of its life is preventative medicine at its best.

Thank you, sir.

Senator INOUE. Admiral?

Admiral ZIMBLE. I would like to echo my colleague's remarks. We have similar points in health care promotion in the Navy: the physical examinations, the blood pressure, the cholesterol levels that we take of all our active duty people. We have no smoking in

any of our medical or dental facilities, and we are active in promotion of smoking cessation classes.

We do that on a very regular basis. We do routine blood pressure checks, not only in our facilities but in the dental facilities as well, and then follow up on those that are problems.

We have dining facility menus that have been altered to meet the American Hospital Association guidelines for fat, cholesterol, sodium, calories, et cetera. We have a very active, very proactive physical readiness program for active duty people.

But I am going to have to echo Dr. Mayer in his statement that we have an implicit benefit to smoking and drinking by giving reduced costs for cigarettes and alcohol in our facilities. That is described as a military benefit, and it is very difficult to overcome that with smoking cessation classes when implicitly we have already suggested to our sailors and marines that one of the advantages you give up when you stop smoking is the ability to get a cut-rate cigarette—a big problem.

And I think we need to take action. It goes beyond the purview of the Surgeons General.

Senator INOUE. General?

ARMY HEALTH PROMOTION

General LEDFORD. Sir, may I compliment my colleagues. The Army is actively involved in health promotion, sir. You will be proud of what we have done, I think. Maybe we are not spending as much of our resources on it as we would like.

This year we have some \$4 million directed toward health promotion. We currently are getting cholesterol analyzers and automation systems worldwide so that we can evaluate the health status of our entire force. We are actively working with the rest of the Army on a physical fitness program. Now, of course, the exercise part of it comes under the aegis of the DESOPS in conjunction with the medical folks. But we are moving along rather well.

We have identified to the Army perhaps more than \$4 million worth of requirements, but I think the program as it is right now is excellent.

And I echo the comments of my colleagues on substance abuse. Each service is working hard on alcohol, drugs, and tobacco.

NURSES AS PROFESSIONALS

Senator INOUE. All of you use the phrase "retention of professionals," and in describing what you meant you always refer to physicians. Do you consider nurses to be professionals?

Admiral ZIMBLE. Absolutely. "Health care professionals" covers all of our officer corps, dental corps, medical service corps, nurse corps, and medical corps in the Navy. They are all health care professionals as far as we are concerned.

Senator INOUE. Is that the same for all the services?

General LEDFORD. You bet.

General MILLER. Absolutely true, sir, for Air Force. I know it is for Army. Jim went down the list. We have a special group we call the Biomedical Science Corps in Air Force that is unique. It includes our lab officers, our psychologists, our physician assistants.

And indeed, I assure you we consider them health care professionals and they were included in those numbers that I provided.

General LEDFORD. Sir, I would echo those sentiments. I gave you some numbers about physicians. I told you that over a period from fiscal 1984 to 1988 that retention of physicians had fallen from 72 to 41 percent.

For nurses it has been sort of poor all along: 58 percent, 54 percent, 60 percent, and last year it was 54 percent. Of nurses that could get out, only 54 percent were retained.

NURSING SCHOOL

Senator INOUE. In order to counter the shortage of physicians, we responded by setting up a medical school here. Why do we not set up a nurses school?

Admiral ZIMBLE. Mr. Chairman, I would personally very much support that initiative. Of course, we do have some nursing schools in this country today that are seeing a dropping enrollment. So one of the fastest things that we can do, and all of the services have it now, is ROTC programs and other initiatives to help support some of our nurses in getting their education.

But a military nursing school is supported by all three of us, as well as the Board of Regents of the Uniformed Services University. It is my understanding that in order to create such a school the Uniformed Services University would have to be awarded the authority to grant a baccalaureate degree.

It currently only has authority to grant advanced degrees. It is my understanding that Dean Sanford is very much in favor of having the ability to provide for a nursing school.

General MILLER. Mr. Chairman, I will take the opportunity to point out to the committee that a goodly portion of nurses that we access today with baccalaureate degrees in nursing have come from schools where the curriculum does not include sufficient clinical instruction, that we now spend time putting them into a nursing internship for a period of 6 months or so after they enter our Air Force.

It is my personal observation that a military nursing school would offer the opportunity, and the time is certainly right to provide the kind of a curriculum that might provide leadership for the rest of our Nation as far as revising nursing curriculum.

We strongly support your suggestion, your idea.

Senator INOUE. I suppose the Army concurs?

General LEDFORD. Yes, sir.

Sir, I should tell you, I have the numbers in front of me. Last year, 1988, was the first year in our history that we fell below our nursing recruitment mission. And so I am concerned about nursing and I would strongly support this initiative.

Senator INOUE. Can you get your heads together and submit to the committee a proposal on how to set up a nurses school and where it might be well established, a campus, et cetera?

General MILLER. There currently is a triservice working group that is exploring those things, Mr. Chairman. And I am sure that my friend would be glad to supply that, along with independent information if you prefer.

MEDICAL AVAILABILITY

Senator INOUE. I have spent over 2 years of my life in military hospitals, one way or the other. And I can tell you that I have personally no complaints to make. I received the best of care, the best of service. It was always courteous, whether it was overseas or back in the continent.

But over the years I have been receiving letters from people all over the United States when they learned of my interest in military health, complaining about service. First, according to the individual poll I have taken, was they agree that the quality of care is excellent. In fact, they say it is better than the civilian sector—good doctors.

But the availability. They say it takes 2 weeks to make an appointment and they have to sit around for 6 hours before they are called up.

What is being done?

General LEDFORD. Sir, that is the problem that I lump under the term "access to care." Access to our system is our biggest problem, and we are doing a lot about it. We are not nearly as far along as we should be. But I can tell you we have a program called the Medical Enhancement Program in the Army.

This is a program that helps us purchase the services of more clerks, more nurses, more ancillary providers, for our physicians, and more appointment personnel. And this year, for example, we have some \$76 million in our budget for this program.

Last year we brought on board 549 ancillary personnel to address just this very problem. We have a long way to go. We are very well aware of it.

SENSITIVITY TRAINING

Senator INOUE. The other complaint—and I do not have it, because I am certain you know that when a U.S. Senator goes to a military hospital, all of a sudden you get the best service, and that is no secret. But when the wife of a sergeant goes there or a corpsman, something like that, the situation changes.

The second complaint I get is that these people go to the hospital feeling distressed and depressed because they want help, and the greeting they get from the first person they meet is not always very sensitive. Do you have any special training for this?

Admiral ZIMBLE. Yes, sir. Mr. Chairman, first of all let me say that one of the problems that will always occur when resources are constrained and unable to meet the demand, and we have people that want to contribute and are frustrated, it becomes very, very difficult for them.

And frustrated people frequently do not make the best diplomats in terms of providing good, compassionate point of access care. We need to address that and we have. We have patient contact point programs that we are emphasizing in our system.

But we have recently worked in conjunction with Air Force to put together a videotape, soon to be distributed along with instructional material, that will help enhance our ability to provide that compassionate care.

One of the things that we have always prided ourselves on in the military is the fact that we do have empathy and that we have not forgotten about the art of medicine in our strides to maintain the state of the art in the science of medicine. We can always do a better job with that and we are continually improving in that.

Our biggest problem is access, and you are right, the second problem is ensuring that those people that greet our patients are appropriately trained to do that job the best way they can. We are working that.

WARTIME CONTINGENCY PLAN

Senator INOUE. The facilities we have today may not be quite sufficient to meet all of the needs of the military family. In some areas, you do not have enough beds. In others you have an overabundance. But this is for peacetime.

Are you satisfied that our contingency plans for wartime are sufficient? Now, for example, I looked over the plans in Korea and right now if you had a minor catastrophe you will have men and women lying out on the sidewalk, because you just do not have that many beds. We have, essentially, a clinic out there.

Are you satisfied?

Admiral ZIMBLE. I suppose each one of us needs to answer that question, because each service has its own program for developing platforms to go to war.

That is for me a very difficult question. When asked how much is enough, my usual answer is, too much is enough. We have to work within constrained budgets. We have to look at worst-case scenarios, and we have to see how we are going to meet that need.

But I would tell you that we are very satisfied that we are making progress toward a programmatic process toward the acquisition of some of those platforms. When I first made flag in 1981, I was medical officer of the Marine Corps. At that time we had no hospital ships in the U.S. Navy. The only fleet hospital was decaying away in Vietnam at Danang, and the last hospital ship was tied up in the Naval Reserve fleet and was rusting away.

Over the course of these 8 years, we now have coming on board into our system—we have already accepted one and the second one is about ready to be accepted—beautiful state-of-the-art hospital ships, 1,000 beds each, 12 operating rooms each, with state-of-the-art equipment on board.

In fact, the only two CAT scans afloat in the free world today are on the NS ships, naval ships *Comfort* and *Mercy*.

In addition, we now have in the program 19 fleet hospitals. Many of them have already reached initial operational capability. And the full program that goes out throughout the out years gives us 23 fleet hospitals.

Is that enough? I do not know. We will look to continue that buildup.

The rapidly deployable medical facility is in existence and is deployed, and that represents 1,000 beds. We have the amphibious ships, the LPH, the LHA, and now the new ship, the LHD, that have very significant medical capabilities on board to take care of the amphibious assault, the initial amphibious assault.

We also have deployable systems within the fleet marine force in our medical battalions, approximately 540 beds in each one of our MEF's. And I could go on. But we have lots of systems in place today with prepositioned supplies that make me feel far more comfortable than I felt in 1981.

We have things still in the program that I am sure will make my successor feel far more comfortable than I do. And I think we have a balanced program for moving ahead with the acquisition of the platforms needed.

What I now need to have is the come-as-you-are force that are ready when our commanders dial 911 and ask for more medical support, that we have our men and women in uniform, our providers, that are ready to respond to that need.

Senator INOUE. Where is the *Mercy* now or the *Comfort*?

Admiral ZIMBLE. The *Mercy* is in Alameda, sir. The *Comfort* is in Baltimore harbor.

Senator INOUE. Right over here?

Admiral ZIMBLE. Yes, sir; and I would invite you to come out and see the *Comfort*. I would be very happy to escort you, sir.

Senator INOUE. I will try to do that at the earliest, because I have never been on a hospital ship.

General MILLER. I can give you a picture, if you will grant me a simplistic answer, as far as Air Force readiness in the Pacific. Again, it is much better than it was a few years ago. With what is in the program, we have about 75 percent of what we judge we need.

It is important to understand, as I am sure you do, Mr. Chairman, that the amount of warning time makes a lot of difference as to whether you have time to deploy medical assets or not. In most scenarios, airbases are expected to be prime targets early on.

We are better off than we were. With some of your assistance and support, I understand the facility at Kimhae is up and ready and running and being exercised, and we are continuing to make progress.

NAPLES HOSPITAL

Senator INOUE. And we are going to get a new hospital in Naples.

Admiral ZIMBLE. I am very grateful, sir. It is long overdue.

Senator INOUE. It is a disgrace.

Admiral ZIMBLE. Yes, sir.

General LEDFORD. Mr. Chairman.

Senator INOUE. General.

General LEDFORD. I visited one of those hospital ships and I can tell you they are terrific. But the Army has got some terrific initiatives, too. We have four 1,000-bed hospitals in Europe that can be staffed and ready to go in 72 hours.

I already told you how proud I am that we have finally done something in the DEPMED's arena. DEPMED's gives us 65,000 beds to be used in the overseas theaters, and we have got 101 out of our 156 hospitals that have already been procured.

So that is good news. Dr. Mayer touched on the national defense medical system, the consortium of civilian hospitals which has

dedicated beds to us, and they have currently dedicated, I think, some 100,000 beds. Without question, these would become available. The civil sector is heavily overbedded right now and I am sure these would be available.

The Veterans Administration—we have really got a cooperative arrangement with them—has dedicated approximately 30,000 beds to the Department of Defense that they think would be available to us within 30 to 45 days.

So I am not sure that any of us could give you the finite answer of how many tens of thousands of beds we really need. I am sure some planner could come up with all kinds of numbers, depending on the scenario. But I can tell you we have come a long way.

Senator INOUE. Thank you very much.

I could sit here all day, but the time is limited. We have other matters to concern ourselves with. And so if I may, I would like to submit to all of you questions for your consideration and response.

I thank you for your contribution this morning. It has been very helpful, and I look forward to your answers to our questions. Thank you very much.

Admiral ZIMBLE. Thank you very much,

General LEDFORD. Thank you, sir.

Senator INOUE. And now if I may, I would like to call upon my favorite people, the nurses.

COMMENDATION FOR NURSES

As I said, you are my favorite people, the nurses. I have spent over 24 months in military hospitals and I cannot say enough for the service I received from nurses. In fact, in the early days I thought that nurses ran the hospitals. That is why I asked the question about professionals, because in the hospitals overseas I saw the nurses every day. They prescribed medicine, they did all the injecting. And once a week the physician came along.

And that is why I could not understand the fuss that we have had all these years in looking upon nurses as professionals and providing them that status of autonomous service, independent service. But I am glad this society is beginning to realize that nurses do not have to walk six paces behind physicians.

I would like to now call upon General Adams-Ender. And before I do, I thank you very much for all the help you have given me over the years.

I am certain you know of our concerns. We have discussed them. You were all sitting there listening to us. Your statements have been received and they have been made part of the record, so I can assure you that they will be part of the record.

So you may proceed as you wish.

STATEMENT OF BRIG. GEN. CLARA L. ADAMS-ENDER, CHIEF, ARMY NURSE CORPS, DEPARTMENT OF THE ARMY

General ADAMS-ENDER. Thank you very much, sir, Mr. Chairman.

Thank you for allowing me to be a part of this historic occasion. As you alluded to earlier, today marks the first time the leaders of the military nurse corps have ever appeared together before a con-

gressional committee. And as friends and colleagues, we are sincere and committed to providing the high-quality nursing care and health care within the military services.

NURSE SHORTAGES

Our reason for being here today is to discuss the nursing shortage all over the country, but with particular emphasis on its effects upon the military services. First I shall relate a brief scenario.

The scene is a large community hospital in Anywhere, USA. The patient is a 57 year old man who has had his right lung removed. He is on a respirator and is classified as seriously ill. He is in an intensive care unit. An observer sees the nurses busily providing compassionate and comprehensive care.

This care is repeated in similar and countless scenarios every minute of every day in this country. Nurses have the awesome responsibilities of intervening in emergent and routine situations, making astute observations, and accurately relaying information which keeps patients alive and progressing toward recovery.

The scenario which I just described is being adversely affected every day by the shortage of professional nurses. According to the recent report of the Secretary of Health and Human Services on Nursing, the Commission, the shortage is due to an increasing demand for nurses. The ratio of nurses to patients has increased from 50 nurses per 100 patients in 1972 to 96 nurses per 100 patients in 1987, and that is nearly a 1-to-1 ratio.

Estimates of additional nurses needed have exceeded a quarter of a million. The demand for nurses has been brought on primarily by the needs of an aging population, the AIDS epidemic, and the increased use of highly sophisticated medical technology.

FACTORS IMPACTING ON DECLINING NUMBER OF NURSES

The Commission concluded that the demand will continue into the foreseeable future. At the same time, the ability to supply registered nurses is adversely affected by declining college age population, expanding career opportunities for women, decreased educational subsidies, deteriorating working conditions, and the negative public image, status, and prestige of the nursing profession.

The Commission made several recommendations of resolutions for the nursing shortage. Briefly, they were: to ensure an appropriate utilization of registered nurses; increase the compensation; and to take immediate action to increase the supply and increase the involvement of nurses at policymaking levels on the National, State, and local levels.

The mission of the Army Medical Department, as the Surgeons General have told us, is to provide the health care services for the Army during war and peace. The mission of the Army Nurse Corps is to provide the nursing care in support of those missions.

SHORTFALLS FOR ARMY NURSES

Shortfalls for Army nurses exist in all components—Active, Guard, and Reserve. And those shortfalls are further exacerbated by the exodus of civilian nurses who normally worked for the

Army and are now electing to return to the private sector for employment for higher salaries and better scheduling.

All of these shortfalls are a direct result of shortages in the civilian sector. The shortages constrain us from simultaneously training for mobilization and providing quality peacetime care.

Corrective actions which the Army has taken to this point in responding to the nursing shortage include: changing recruitment policies, giving educational guarantees, implementing congressionally mandated stipend and loan repayment programs, and increasing the recruiting force. Despite these actions, our ability to recruit and retain sufficient numbers of qualified nurses will be virtually impossible without additional short- and long-term assistance.

Actions needed include establishment of alternative methods of recruiting professional nurses, loan repayment program reforms, new ways to increase the marketability of Army nursing, and initiatives to ensure a steady flow of accessions.

Army nurses have a proud and long tradition of having served soldiers and their country well during war and peace. We have always been there when we were needed. My visit here today is to tell you that Army nurses are still committed to providing high-quality care to soldiers. However, we need assistance in these worsening times in nursing and in health care.

Thank you, Mr. Chairman, for the opportunity to address the subcommittee. I look forward to your questions.

Senator INOUE. Thank you, General.

[The statement follows:]

STATEMENT OF BRIG. GEN. CLARA L. ADAMS-ENDERS

Mr. Chairman, distinguished subcommittee members, ladies and gentlemen. Thank you for allowing me to be a part of this historical event which marks the first time military nurse corps chiefs and directors have appeared before a Congressional Committee. It is a singular honor and pleasure for us to be here today. Our appearance certainly emphasizes your concern for military health care issues and, more specifically, those related to provision of nursing care--the foundation of any health care system. With this written testimony, my objectives are to familiarize you with 1) the state of nursing in America today, 2) the state of Army nursing today, and 3) some assistance needed to alleviate the shortage.

In the United States today, professional nurses have been determined to be in short supply and in great demand based upon a number of indicators. According to the recent report of the HHS Secretary's Commission on Nursing, the shortage of registered nurses (RN) is due to an increasing demand for nurses which will continue into the foreseeable future. The increased demand for RNs has been brought on primarily by the nursing care needs of an aging population, highly sophisticated medical technology and the AIDS epidemic. Moreover, the ability to supply RNs has been adversely affected by a declining college-age population, expanding career opportunities for women, decreased educational subsidies, deteriorating working conditions, and the negative public image, status, and prestige of the profession.

The nursing profession provides a necessary and valuable service in the health care system. The RN must constantly demonstrate the knowledge and skill to make astute observations, provide appropriate intervention and to do accurate reporting and teaching in caring about patients in a variety of settings. The nursing process, which is a systematic way of organizing for delivery of care, must be fully understood and used by the RN in order to ensure that patients receive comprehensive care that is of high quality. In essence, it is the responsibility of the nurse to make those astute observations and appropriate judgments to keep patients alive and progress toward recovery.

The implications of the shortage in supply and demand of RNs are serious given their immense responsibilities in the health care arena. The Commission on Nursing Report observes that the increasing demands for nursing services will increase the workload for each RN and adversely affect the quality of nursing care. The deteriorating work environment will have an impact upon each RN by increasing stress and decreasing morale. There will be a reduced access to care in a variety of settings with a persistent and prolonged shortage. In addition, passage of additional health care legislation which increases access will also create a greater demand for nursing personnel. Unless there are definitive steps taken to reduce the demographic trends which are currently affecting the supply of RNs, the outlook for a timely resolution to the shortage is discouraging.

The Health and Human Services (HHS) Commission on nursing made several recommendations for resolution of the nursing shortage. In summary, they were: 1) utilization of nursing resources for providing direct care to patients and families and not for non-clinical duties, 2) increasing RN compensation, 3) reimbursement of health care delivery organizations at sufficient levels to recruit and retain an appropriate number and mix of nurses to provide adequate patient care, 4) active participation of RN in policy-making at national, state and local levels, 5) financial assistance for the development of nursing resources, and 6) development of mechanisms for monitoring the maintenance of nursing resources. For the first time in any nursing study, the need of the military nursing system to participate in combat medical readiness was acknowledged. While many of the causes and solutions to resolving the nursing shortage were the same in the military sector as in the civilian sector, an additional

important and overriding implication is the potential adverse effect upon national security in the United States. Moreover, the shortage of nurses in the civilian sector has an immediate impact upon the military because of its need to draw nurses from the same pool for recruitment into the services.

The mission of the Army Medical Department (AMEDD) is to provide health care services for the Army during peacetime and in case of mobilization. The mission of the Army Nurse Corps is to provide the nursing care services in support of the AMEDD and the Army. There are shortfalls which exist in the current inventory and additional ones projected in the future. For example, as of 31 January 1989, there were 4390 Army nurses on active duty with an authorization for 4965. There were 1156 assigned in the Army National Guard with an authorization for 1212, and 6540 nurses in the Army Reserve Troop Program Units with an authorization for 8449. In addition, the individual ready reserve had 3369 nurses assigned with a requirement for 12,822 during mobilization. Finally, 2260 Civil Service RNs were assigned to bedside positions with an authorization for 2611.

There are definite signs that projected shortfalls will increase in the future if no action is taken to reverse the downward trend. Some of these objective signs are a decrease in the number of active duty Army Nurses requesting career status, a lag in the number of accessions in the recruiting system when compared to timelines from previous years, an exodus of DA civilian RNs from Army MTPs to seek employment in civilian sector because of higher salaries, and a substantial decrease in the ability of recruiters to market reserve duty as attractive part-time employment.

Army nurse shortfalls have serious implications both for peacetime and mobilization missions. The shortages prohibit us from being able to manage the nursing workload for soldiers, their families and other eligible beneficiaries on a daily basis, thereby decreasing the quality of life and health which should be available at all times. Army nurses must constantly prepare for their mobilization mission by participation in readiness activities periodically. When shortfalls exist in the inventory, both in the active and reserve components, it makes the successful completion of these requirements much more difficult and places the state of nurse readiness in jeopardy. Moreover, the entire AMEDD mission is placed in jeopardy when there are insufficient nurses available to support medical care.

Numerous corrective actions have been taken to alleviate the shortage. For the active component, policy changes have been made for recruitment, additional course guarantees have been given for desirable specialties, and retention reforms have been instituted. For the reserve components, Congressional actions in 1986 resulted in initiation of stipend and loan repayment programs. Additionally, there has been an increase in the recruiting force, policy changes to expand the recruiting population and the establishment of a national AMEDD augmentation detachment to enhance training flexibility. For the DA civilian RNs, actions have been taken to obtain special salary rates, increase recruiting incentives and to upgrade current positions.

Despite these initiatives, the ability to recruit and retain sufficient numbers of RNs for the Army in the future will be impossible without additional short and long term assistance. There needs to be alternative methods established to recruit RNs, the need for assistance with repayment of student loans, methods to increase the marketability of Army nursing and initiatives which will ensure steady state accessions for Army nurses in the mid-range period. In addition, potential reservists need to have additional options open to them to seek reserve duty as a fulfilling and challenging choice of part-time employment. Finally, actions must be pursued to establish professional career ladders for DA civilian RNs.

Army nurses have a proud tradition of having served soldiers and their country well during peace and war. They have always been there when they were needed. My visit here today is to apprise you of the facts that Army nurses are still committed to providing high quality care with kindness to soldiers, their families and other beneficiaries. The ability to accomplish this mission has become virtually impossible with the increased demand, supply and competition for RN services today.

Thank you for the opportunity to address you today about the very vital and timely issue of the nursing shortage in the Army.

BIOGRAPHICAL SKETCH

Brigadier General Clara L. Adams-ENDER was born in Wake County, North Carolina, the fourth oldest of ten children. She received her baccalaureate degree in nursing from North Carolina Agricultural and Technical State University, Greensboro, North Carolina, a Master of Science Degree in Nursing from the University of Minnesota, and a Master of Military Art and Science Degree from the U.S. Army Command and General Staff College. Her military education includes graduation from the command and General Staff College, Fort Leavenworth, Kansas, and the U.S. Army War College, Carlisle Barracks, Pennsylvania.

A veteran of 29 years in the Army, General Adams-ENDER has held such diverse assignments and Chief Nurse of two Medical Centers, Assistant Professor of Nursing, Inspector General, and Chief Army Nurse Recruiter. Her overseas assignments include Korea and West Germany, where she served as an Intensive Care Nurse, REFORGER Chief Nurse, Medical Center Chief Nurse, and Nursing Consultant.

General Adams-ENDER served as Chief, Department of Nursing, Walter Reed Army Medical Center, Washington, DC, from June 1984 to August 1987 and is certified in Advanced Nursing Administration by the American Nurses Association. Other awards and decorations include the Legion of Merit, the Meritorious Service Medal with three Oak Leaf Clusters, the Army Commendation Medal, the coveted Surgeon General's "A" professional designator for excellence in nursing administration, the Roy Wilkins Meritorious Service Award of the National Association for the Advancement of Colored People, and membership in the Order of Military Medical Merit.

In 1967, General Adams-ENDER became the first female in the U.S. Army to qualify for and be awarded the Expert Field Medical Badge. In 1980, she became the first and only nurse and female to be senior marcher for 700 U.S. Army Europe soldiers in the 100 mile, four day march in Nijmegen, Holland. In 1987, she became the eighteenth Chief of the Army Nurse Corps and in 1988, became the first Army Nurse Officer to be appointed as Director of Personnel for the Surgeon General of the Army. General Adams-ENDER is a member of the Association of the United States Army, Association of Military Surgeons of the United States, the American Nurses Association, the National League for Nursing, the American Organization of Nurses Executives, Sigma Theta Tau Honor Society, and Chi Eta Phi Sorority.

**STATEMENT OF REAR ADM. MARY F. HALL, NURSES CORPS, U.S. NAVY,
DIRECTOR, NAVY NURSE CORPS, DEPARTMENT OF THE NAVY**

Senator INOUE. Admiral Hall.

Admiral HALL. Good morning, Mr. Chairman and members of the subcommittee.

I am Rear Adm. Mary Hall. I am Director of the Navy Nurse Corps. As the Navy Nurse Corps Director, I am responsible to the Navy Surgeon General for the administration, direction, and coordination of approximately 3,000 active duty and 1,500 Reserve Nurse Corps officers. The primary responsibility of the Navy Nurse Corps is to provide professional nursing care to and promote the health of active duty Navy and Marine Corps personnel and all others as authorized by law.

The Navy Nurse Corps also has a secondary responsibility, to provide ongoing instruction for and supervision of our hospital

corps personnel in the theory and practice of nursing during peacetime, in order to benefit our recipients during mobilization.

PATIENT CARE MOST IMPORTANT

The provision of nursing care by Navy nurses operates within unique health care delivery settings that are diverse, complex, and constantly changing. The most important activity performed by medical treatment facilities, medical department personnel and facilities, clinics, field hospitals, and ships is patient care.

Clinical nursing is one of the cornerstones of this activity. Therefore, the need to maintain an adequate number of qualified nurses in the Department is absolutely essential to the success of Navy medicine's mission.

RECRUITMENT

As to recruitment, the Navy is having a difficult time recruiting nurses. Over the past 3 years the Navy has not met its recruitment goal for nurses. The worst year by far was 1988, when only 62 percent of the nurse recruitment goal was met.

At the very best, the Navy anticipates accessing only 70 percent of the nurses needed to meet our goal for this year. The two principal factors contributing to poor nurse recruiting success are declining enrollment in schools of nursing and a changing, competitive market.

The recruitment of experienced specialists from the civilian market, such as nurse anesthetists, critical care, and operating room nurses, is equally problematic. Again, during the past 3 years the Navy has been unable to recruit certified nurse anesthetists. At present, the Navy Nurse Corps is 26 below our authorized level for this specialty.

RECRUITING

Our difficulty, sir, in recruiting these professional nurses is because of noncompetitive salaries and lack of benefits, and it represents a serious threat to our mission.

RETENTION

The inability of the Navy to retain qualified professional nurses, especially after the 3-, 11-, and 20-year career marks, has far-reaching implications. Although a certain amount of turnover is necessary, the economic impact of poor retention can be considerable. For example, the direct cost of replacing a registered nurse in the civilian community has been estimated to range from \$2,500 to \$12,000.

Although the direct costs of replacing a single-tour Navy Nurse Corps officer has never been estimated, the cost of recruitment and initial military training alone easily exceeds that \$12,000 and is probably closer to \$20,000. Coupled with these costs are such non-measurable costs as inefficiency of having all these new personnel and lower productivity due to decline in morale.

At its extremes, our inability to retain qualified nurses threatens the effectiveness of our treatment facilities, in that the opportunity

for a large corps of experienced nursing professionals to be present in each patient care area on a day-to-day basis never materializes.

As a result, our goal of providing patients with quality care becomes increasingly difficult to achieve.

RECRUITMENT SOLUTIONS

Under solutions for recruitment, during the past 1½ years a number of systemwide initiatives have been implemented to increase the Navy's competitive edge with respect to professional nurse recruitment. The maximum accession age for professional nurses was increased from 35 to 40 for Active duty and from 40 to 47 for our Reserves.

As of December 4, 1987, we had constructive credit back for us. Up to 3 years was granted for professional civilian nursing experience. Additional constructive credit for special preparation in selected critical nursing specialties has also been authorized by the services. However, I have some concern that we will not be able to fully exploit this program because of our officer grade strength limitations.

These initiatives, particularly the increased maximum accession age, must continue. The need for Navy Nurse Corps officers prepared at the graduate level to meet the growing demands of our increasingly complex health care delivery system both in peacetime and during mobilization will continue.

However, our primary accession focus remains the baccalaureate-prepared registered nurse. Therefore, scholarship programs which support a variety of avenues whereby baccalaureate degree completion nursing can occur will ensure our success in the educational marketplace.

It is my belief, sir, that the Navy's inability to recruit and retain professional nurses has and will continue to impact adversely on the Navy Medical Department. Contracting of our emergency departments and critical care units, bed closures, and low morale are painful reminders of our present situation.

I support General Adams-Ender's comments and initiatives, and on behalf of both Active duty and Reserve Navy Nurse Corps officers, I respectfully request your support, sir. Thank you.

Senator INOUE. Thank you very much, Admiral.

[The statement follows:]

STATEMENT OF REAR ADM. MARY F. HALL

Good afternoon Mr. Chairman and members of the Subcommittee. I am Rear Admiral Mary Hall, Director of the Navy Nurse Corps. As the Navy Nurse Corps Director, I am responsible to the Navy Surgeon General for the administration, direction and coordination of approximately 3000 active duty and 1500 reserve Nurse Corps officers. I have been the Navy Nurse Corps Director for almost one and one-half years and have been a Navy Nurse for over thirty years.

The primary responsibility of the Navy Nurse Corps is to provide professional nursing care to and promote the health of active duty Navy and Marine Corps personnel and all others as authorized by law. During times of mobilization, the Navy Nurse Corps' major responsibility is to meet the patient care needs of the operating forces of the Navy and Marine Corps. The Navy Nurse Corps also has a secondary responsibility to provide ongoing instruction for and supervision of Hospital Corps personnel in the theory and practice of nursing during peacetime and during mobilization. This secondary responsibility involves, at any given point in time, some 10,000 Hospital Corps personnel involved in direct patient care in our Navy Medical treatment facilities.

The provision of nursing care by Navy Nurses operates within unique health care delivery settings that are diverse, complex, and constantly changing. Examples include, but are not limited to, hospital ships, fleet hospitals, and fixed medical treatment facilities having both inpatient and outpatient services.

As a clinician, the Navy Nurse must possess the versatility to function within a variety of practice settings and clinical specialties and to do so more independently than his or her civilian counterpart. As an educator and manager, the Navy Nurse must possess the competencies to provide instruction and supervision for junior nurse Corps officers who are new to the profession and to military service. The Navy Nurse must also provide instruction and supervision for Hospital Corps personnel who have had

no previous experience caring for the ill. The requirements placed upon Navy Nurses by virtue of their commission as Naval Officers provide still another distinguishing feature between Navy and civilian nursing practice. Regardless of one's primary professional affiliation (e.g., law, engineering, business, nursing), a Navy commission in the active duty or reserve forces means first, and foremost, the taking on of another professional identity - that of Naval officer. Fundamental to this second profession is greater responsibility and authority, and greater accountability for decisions made and actions taken.

For the nursing professional, a Navy commission means a greater requirement to: 1) continually educate and train those who will serve in his or her stead in time of conflict (e. g., the Navy corpsman), 2) serve as a role model or mentor for all junior and/or less experienced personnel, 3) provide leadership, management, and planning expertise in collaboration with and support of all members of the health care delivery team, and 4) maintain an attitude of flexibility and readiness to provide care anytime, anyplace, anywhere.

The most important activity performed by Navy Medical Department personnel in our facilities, clinics, field hospitals, and ships is patient care. Clinical nursing is the cornerstone of this activity. Therefore, the need to maintain an adequate number of qualified nurses in the Navy Medical Department is absolutely essential to the success of Navy Medicine's mission. Maintaining adequate numbers of qualified nurses requires the ability to recruit nurses from the civilian community and retain qualified, experienced nursing professionals who serve the Navy so distinctively.

RECRUITMENT

The Navy is having a difficult time recruiting nurses. Reasons for this difficulty include; 1) the explosive demand and competition for professional nursing services in this country, 2) the current trend of declining admissions and enrollments in nursing schools, and 3) shifting patterns of employment for nurses from full-time to part-time.

Over the past three years, the Navy has not met its recruitment goal for nurses. The worst year by far was 1988, when only sixty-two percent (62%) of the nurse recruitment goal was met. At present, with almost twice as many officers devoted to recruiting nurses and physicians as last year, the number of nurses selected and accessed into the Navy Nurse Corps remains equal to those numbers selected and accessed this time last year. At the very best, the Navy anticipates accessing only seventy percent (70%) of the numbers of nurses needed to meet our goal for this year.

The declining enrollments in schools of nursing have and will continue to have a major impact on our ability to recruit professional nurses as the majority of our accessions come from this important pool. Declining enrollment represents only part of the problem with respect to our current recruiting situation. Entry level professional nurses in the private sector frequently are provided starting salaries and benefits by our civilian competitors which more and more exceed the starting salary and benefits we offer.

This combination of declining enrollments and increasing civilian salaries presents a major obstacle to our ability to recruit the numbers of junior Nurse Corps officers we need to meet our specialty in-house training requirements for nursing anesthesia, critical care, medical-surgical and operating room nursing.

The recruitment of experienced specialists from the civilian market such as nurse anesthetists, critical care and operating room nurses is equally problematic. Again, during the past three years, the Navy has been unable to recruit Certified Nurse Anesthetists. At present the Navy Nurse Corps is twenty-six (26) below our authorized level for this specialty. Projections for the next three fiscal years show no signs of improvement. In spite of a popular, well-established in-house training program in which Nurse Corps officers become Certified Nurse Anesthetists, our overall losses continue due to retirement and resignation to enter the private sector at higher salary levels. Our difficulty in recruiting these professionals because of noncompetitive salaries and benefits represents a serious threat to our mission.

RETENTION

The inability of the Navy to retain qualified professional nurses, especially at the three, eleven and twenty year career marks, has far-reaching implications. Although a certain amount of turnover is necessary, the economic impact of poor retention can be considerable. For example, the direct costs of replacing a registered nurse in the civilian community has been estimated to range from \$2,500 to \$12,000. Although the direct costs of replacing a single tour Navy Nurse Corps officer has never been estimated, the cost of recruitment and initial military training alone easily exceeds \$12,000 and probably is closer to \$20,000. Coupled with these costs are such nonmeasurable costs as inefficiency of new employees and lower productivity due to a decline in morale. These nonmeasurable costs are compounded given the routine turnover associated with frequent reassignments characteristic of military life.

The impact of poor retention of qualified Nurse Corps officers places the Navy at risk in other ways. When individuals leave an organization voluntarily, they may share complaints and frustrations with fellow employees regarding their jobs, causing others to question their own job satisfaction. As a result, a single termination may precipitate a series of terminations. The effect of this on the recruitment of future generations of nurses can be significant.

At its extreme, our inability to retain qualified nurses threatens the effectiveness of our treatment facilities in that the opportunity for a large core of experienced nursing professionals to be present in each patient care area on a day-to-day basis never materializes. As a result, our goal of providing patients with quality care becomes increasingly difficult to achieve.

SOLUTIONS

RECRUITMENT

During the past year and one-half, a number of system-wide initiatives have been implemented to increase the Navy's competitive edge with respect to professional nurse recruitment. Some of these initiatives have also been implemented by the Army and Air Force.

Increased Age and Constructive Credit

Beginning July 11, 1987 the maximum accession age for professional nurses was increased from 35 to 40 for active duty and from 40 to 47 for reserve. As of December 4, 1987, constructive credit up to three years was granted for professional civilian nursing experience. Additional constructive credit for special preparation in select critical nursing specialties has also been authorized by the services. I must caveat my enthusiasm for the constructive credit authorization. I have some concerns that we will not be able to fully exploit this program because of officer grade strength limitations. We are studying this issue more carefully. Nevertheless, these recruiting initiatives go far in acknowledging, and hopefully attracting, a large segment of civilian nursing professionals whose expertise and training will benefit us. These initiatives, particularly the increased maximum accession age for active duty, must continue.

Scholarship Programs

Two advanced degree scholarship accession programs are under consideration by DOD as recruitment tools to attract nurses into graduate nursing education programs to meet current and projected shortfalls in required wartime nursing specialties. The Armed Forces Health Professions Scholarship Program is one means of accomplishing this and a request for a total of five (5) scholarships for fiscal year 1989 and ten (10) for fiscal year 1990 has been requested for nursing anesthesia, emergency/trauma and critical care nursing. The Full Time Outservice Program is the second scholarship program the Navy is using as a means of recruiting civilian and selected reserve nurses into graduate nursing programs. This program is available to those individuals interested in becoming nurse anesthetists, critical care specialists and family nurse practitioners.

The need for Navy Nurse Corps officers prepared at the graduate level to meet the growing demands of our increasingly complex health care delivery system both in peacetime and during mobilization will continue. However, our primary accession focus remains the

baccalaureate prepared registered nurse. Scholarship programs which support a variety of avenues whereby baccalaureate degree completion in nursing can occur, will ensure our success in the educational marketplace. Two such scholarship programs are in place for the Navy and a third is being considered.

The first program is the Reserve Officer Training Corps (ROTC) Scholarship Program which has been utilized successfully by both the Army and Air Force to recruit baccalaureate prepared nurses. The Navy has recently extended its Navy ROTC Scholarship Program to include well-qualified men and women enrolled in accredited schools of nursing.

The Baccalaureate Degree Completion Program is the second

scholarship program utilized by the Navy primarily in support of members of ethnic minorities who are enrolled full-time or accepted full-time into the junior or senior year of an accredited baccalaureate nursing program.

The Nurse Corps Candidate Program is a third program we are considering. The Nurse Corps Candidate Program was used by the Navy during the 60's and early 1970's and proved to be a very effective recruitment tool.

We are also working with the other services and the Office of the Secretary of Defense to carefully study our competitiveness in the nurse recruiting market. Increasingly, we see private sector recruiters using signing bonuses and retention bonuses to recruit and hold onto professional nurses. This is but one indication of our changing recruiting environment. Therefore, we are working with the Office of the Secretary of Defense to study incentives for attracting nurses into the services so we can do a better job of retaining critical specialty and other professional nurses at the three-, eleven- and twenty-year career marks. We are conducting similar analyses for our reserve component programs.

SUMMARY

It is my belief that the Navy's inability to recruit and retain professional nurses has - and will continue to impact adversely on the Navy Medical Department. Contracting of our emergency departments and critical care units, bed closures and low morale are painful reminders of our present situation. On behalf of both active duty and reserve Navy Nurse Corps officers, I respectfully request your support.

STATEMENT OF BRIG. GEN. BARBARA A. GOODWIN, THE CHIEF NURSE,
U.S. AIR FORCE

Senator INOUE. General Goodwin.

General GOODWIN. Good morning, sir.

Mr. Chairman and members of the committee, thank you for your kind remarks about nursing. We do appreciate those. And as my contemporaries here, I, too, am delighted to be here to have the opportunity to discuss with you Air Force nursing concerns.

The Air Force medical service has a mission to provide health care services at 121 medical treatment facilities around the world. Of these, 80 are hospitals and medical centers and 69 of those, a full 86 percent, have less than 100 beds.

RECRUITING AND RETENTION DIFFICULTIES

We are beginning to experience difficulty recruiting and retaining nurses to staff these facilities, as well as to meet our readiness mission. The Recruiting Service has been able to meet its Nurse Corps goals for the past several years. However, this year we may not be as successful. By the end of January, the Recruiting Service had accessed only 31 percent of its nurse goal of over 600 for this fiscal year, due to a sharp decrease in applications.

If the 5-year historical data prove consistent, that of achieving 50 percent of the goal by January, a significant shortfall of nurses will result.

SHORTAGE OF ANESTHETISTS

Our most critical need is for certified registered nurse anesthetists. We anticipate a shortage of 31 of these specialists through 1990. The number joining the Air Force has steadily decreased because of spiraling civilian salaries and our inability to provide adequate promotion opportunity for these specialists. So far this year, despite the urgent need and intensified efforts of our recruiters, we have not recruited one single nurse anesthetist.

Retention rates for the Air Force Nurse Corps have steadily declined over the past 2 to 3 years. The overall retention rate in 1988 for nurses remaining at least 1 year beyond their initial obligation was the lowest since 1981.

Further, a 1988 Nurse Corps survey suggested that career intent has dropped 5 percent in the last 2 years. Nurse retention is influenced by factors such as promotion potential and compensation. In order to improve promotion and retention, we are currently doing an extensive review of the requirements for field grade, our major and above ranks.

POSITIONS FOR THE NURSE CORPS

Recognizing the changes in health care delivery practice and the increased nursing requirements of hospitalized patients, we believe the structure of our nurse force demands increased experience levels in all areas of clinical practice.

As you mentioned earlier, the nurse is the critical element in the 24-hour-a-day assessment and monitoring of patients in our hospitals. It is the nurse's responsibility to accurately determine when a

change in a patient's condition warrants physician intervention. It is also essential that the nurse be experienced in the management of patient care and recognize when available resources are not adequate to provide safe care.

Thus, as well as recruiting fully qualified nurses, it is essential that we retain experienced nurses by providing appropriate promotion and career progression opportunities. This is especially critical because of the large number of small facilities that we have.

The shortage of nurse anesthetists is a special concern for us in the Air Force because of our reliance on these specialists, again in our small facilities. Air Force-wide, more than 70 percent of our hospitals have fewer than 50 beds. Of those facilities, 33 are staffed with 2 nurse anesthetists and no anesthesiologists. And six of those two-person facilities will be only 50 percent staffed by the end of this fiscal year, with no replacements available.

This situation will significantly impact our ability to provide needed services for our patients, decrease productivity, and increase CHAMPUS costs. We cannot allow this to occur, nor to lose the valuable and highly trained providers, our nurse anesthetists, because their compensation lags so far behind the civilian sector.

The Air Force Nurse Corps has a proud history. To maintain our tradition of excellence, we must continue to attract and to retain adequate numbers of qualified nurses, specialists and generalists as well. This will take strength from within and also support from outside of the Nurse Corps.

We need your help in providing scholarship support, special pay for our specialists, and accession bonuses to encourage recruiting.

The effects of the nursing shortage are well documented in the civilian press. This Nation cannot permit military nursing to become a casualty in the growing competition for nursing resources. With your help, we can avert that.

That concludes my remarks.

[The statement follows:]

STATEMENT OF BRIG. GEN. BARBARA A. GOODWIN

Mister Chairman and members of the committee, it is my pleasure to be here this morning to discuss Air Force nursing concerns. The national nursing shortage is well documented. The increased demand for nurses cuts across all health care delivery systems and all nursing practice areas. Nursing programs no longer attract great numbers of applicants, and in some parts of the country nursing education programs have closed. Civilian salaries and benefits for nurses have increased dramatically in many areas in response to the shortage. With increased career opportunities for today's young people, coupled with a small population of 18-20 year olds, the current shortage is not expected to be short-lived. It is projected that by 1990 there will be a shortage of some several hundred thousand nurses in the country. This situation, coupled with factors unique to military nursing, has affected recruiting and retention of Air Force nurses for the first time in many years.

We must continue to attract adequate numbers of qualified nurses to our Corps to support the Air Force. The Air Force Medical Service has a mission to provide health care services for active duty members, their families and retired members and their dependents, at 121 medical treatment facilities around the world. Hospital and medical centers comprise 80 of these facilities and 69 of these (86 percent) have fewer than 100 beds.

The wartime requirement for active duty nurses totals 6297. FY 89 Nurse Corps authorizations in FY 89 total 5345. Staffing at the end of the 1st quarter of FY 89 was 5203. Continued FYDP growth is expected for the Nurse Corps through FY 91.

Even though the Recruiting Service met its Nurse Corps recruiting goals for the last few years, FY 89 may not be as successful. Over the past five years, approximately 50 percent of our annual accession goal was attained by the end of January (four months into the fiscal year). By the end of January 1989, the Recruiting Service accessed only 31 percent of its FY 89 Nurse Corps goal for this year, due to a sharp decrease in applications. If the five year historical data prove consistent, a significant shortfall of nurses will result.

Our most critical need is for certified registered nurse anesthetists (CRNAs). We anticipate a shortage of 31 nurse anesthetists through fiscal year 1990. In 1987 we recruited only 8 CRNAs, and in 1988 only 7. This is a profound change from 1984, when we recruited 30 CRNAs without difficulty. The number joining the Air Force has steadily decreased because of spiraling civilian salaries and our inability to provide adequate promotion opportunity for these specialists. So far this year, despite the urgent need and intensified efforts of our recruiters, we have not recruited a single nurse anesthetist. While recruitment is progressively less successful, requirements for nurse anesthetists are increasing and losses are serious.

The shortage of nurse anesthetists is a special concern for the Air Force because of our reliance on these specialists in our small hospitals. At many small hospitals, there is no anesthesiologist on staff. Air Force wide, more than 70 percent (57) of our hospitals have fewer than 50 beds. Although we try to maintain CRNA staffing at 100 percent for our overseas facilities, 42 percent of Air Force medical facilities in CONUS are currently short of nurse anesthetists. Thirty-three of these hospitals are staffed with two CRNAs and no anesthesiologist. Six of these two person facilities will be 50 percent staffed by the end of this fiscal year, with no replacements available.

Other specialists are also in short supply. We need to recruit 14 nurse midwives this fiscal year, and to date, we have only attracted one to

the Air Force. These critical shortages lessen our capability to perform surgical cases and to provide full obstetrical care. Ultimately, the result is increased CHAMPUS costs, decreased productivity within our hospitals and a declining level of support to the men and women in uniform.

Reserve Forces

The Air Reserve Forces make a significant contribution in both peacetime and wartime. Currently, these elements of the Total Force are tasked to provide 35 percent of our wartime medical manpower requirement. Together, the Reserve Forces comprise 70 percent of our second echelon tasking, 75 percent of our CONUS augmentation tasking, and 97 percent of our aeromedical evacuation wartime capability.

The projected Air Force Reserve Component wartime requirement for nurses is over 9,000, but there is a shortfall of approximately 4,800 at present. Consequently, the Air Force's ability to staff the required 21,000 beds in the theater of operation, and operate 12,000 expansion beds in CONUS, is limited. In addition, the capability to provide front line, forward-based emergency medical care and operate a worldwide aeromedical evacuation system during a global contingency is reduced. Contingency nursing shortages are particularly acute in the specialties of operating room nursing, nurse anesthesia, critical care, trauma, medical/surgical, and flight nursing.

Retention

Retention rates for the Air Force Nurse Corps have steadily declined since FY 86. The overall retention rate in FY 88 for nurses remaining at least one year beyond their initial obligation was the lowest since FY 81. The five-year average retention rate for clinical nurses one year beyond initial obligation is 63 percent. By comparison, the Cumulative Continuation Rate (CCR) for the Nurse Corps was the lowest in five years, 28.5 percent versus 43 percent CCR for Air Force pilots. Low promotion opportunities in the Air Force and higher salaries in the civilian community will undoubtedly hasten the existing downward trend in Nurse Corps retention.

A 1988 Air Force Nurse Corps survey suggests that job satisfaction and career intent remain high in the Nurse Corps, yet there are changes evident since a 1986 survey. Career intent has dropped 5 percent in those two years. The top three retention factors are now retirement benefits, pay and allowances, and job security. More than half (54 percent) of Nurse Corps respondents were concerned with the current promotion system. About the same number (53 percent) believe that they are not adequately compensated for their contribution to the Air Force. They report working long hours (46 percent said more than 50 hours per week) and maintaining a heavy workload.

It is not surprising that nurse retention is influenced by factors such as promotion potential and compensation. These findings are supported by the report of the Health and Human Services Secretary's Commission on Nursing and by the Department of Defense Health Professionals Special Pays Study. The 1988 DOD Health Professionals Special Pay Survey found that over 75 percent of nurse respondents do not agree that the present compensation system is adequate to attract new people, and 79 percent did not agree that the current system is adequate to retain people.

The Air Force has undertaken a number of initiatives to assist in attracting and maintaining a quality force. Our nurse anesthesia and nurse midwifery programs are now affiliated with universities and will now offer graduate degrees. The University of Texas Health Sciences Center in San Antonio will begin a program to award a Master of Science in Nursing degree

with a clinical specialty in Nurse Anesthesia. Twenty Air Force nurses will enter the first class in September 1989. The two-year program will include on-campus academic education, as well as clinical practice experience at selected Air Force facilities. A master's degree program in nurse-midwifery is established at Georgetown University, with clinical affiliation at Malcolm Grow USAF Medical Center, Andrews Air Force Base, Maryland. These two educational programs exemplify the high priority we have given to the quality preparation required of these valuable practitioners.

The Air Force Nurse Internship Program is a successful initiative begun in 1977 to provide clinical experience under preceptorship for initial active duty nurses with no previous clinical work experience. Approximately 200 nurses a year complete this program at various Air Force hospitals. This program remains a consistently attractive recruiting incentive.

Flight nursing is another attractive program because of the opportunity to provide nursing care for patients who are aeromedically transported to regional medical facilities around the world. We are the only military nurse corps with this unique nursing specialty.

Scholarship opportunities also help to enlarge our potential applicant pool. We have increased the number of Air Force ROTC scholarships for nursing education to 250 this year. In addition, we added the option for four-year ROTC sponsorship to the existing two and three-year programs. We anticipate that this will encourage qualified students to consider military nursing as a career choice.

Currently all three military nurse corps are involved in a study to determine the feasibility of starting a uniformed services school of nursing to maintain a ready pool of accessions into military nursing. The study is in its very early stages and data collection is just beginning.

In order to improve promotion and retention, we are currently doing an extensive review of requirements for field grade officers for the Air Force Nurse Corps. Recognizing the changes in health care delivery practices and the increased nursing requirements of hospitalized patients, we believe the structure of our nurse force demands increased experience levels in all areas of clinical practice. This is especially critical because of the large number of small facilities within the Air Force Medical Service.

The nurse is the key element in the 24-hour a day assessment and monitoring of patients in our hospitals. It is the nurse's responsibility to accurately determine when changes in a patient's condition warrant physician intervention. It is also essential that the nurse be experienced in the management of patient care and recognize when limited resources are not adequate to provide safe, quality care. Consequently, as well as recruiting fully qualified nurses, we must also retain experienced nurses by providing appropriate promotion and career progression opportunities.

Granting entry grade credit for civilian experience and increasing the maximum age for accession have helped the Nurse Corps. These initiatives have allowed recruitment of more experienced nurses; the new maximum accession age also opened potential recruitment of older nurses seeking a career change.

However, while the concept of the expanded constructive service credit authority would appear to have high potential for recruiting large numbers of experienced nurses, the extent to which the Air Force will be able to

utilize the authority in inherently restricted by force management requirements. As more experienced nurses enter at grades greater than O-1 due to constructive service credit, it becomes increasingly difficult to maintain promotion opportunity and flow points, as well as grade table controls, within statutory parameters. The increased recruitment of nurses who receive constructive service credit will therefore present considerable challenges to promotion planning and force management for both the active and reserve components. Furthermore, if we fail to meet the challenge of retaining the brightest and the best of our nurses, it will not matter how successfully we recruit.

The Air Force Nurse Corps has a proud history. We have overcome many challenges to achieve excellence in nursing practice. To maintain our position of leadership will take strength from within and support from outside the Nurse Corps. We need your help in providing scholarship support, special pays for selected specialists, and accession bonuses to encourage recruiting.

The effects of the nursing shortage are well documented in civilian medicine. This nation cannot permit military nursing to become a casualty in the growing competition for nursing resources. With your help we can avert this. That concludes my remarks, I will be happy to answer your questions.

BIOGRAPHICAL SKETCH

Brigadier General Barbara A. Goodwin is chief of the U.S. Air Force Nurse Corps, Office of the Surgeon General, Headquarters U.S. Air Force, Washington, D.C.

General Goodwin was born Dec. 23, 1938, in Philadelphia and graduated from St. Mary's High School, Brookline, Mass., in 1956. She received a nursing diploma from Boston City Hospital School of Nursing in 1959, a bachelor of science degree from the University of Pennsylvania School of Nursing in 1968 and a master of science degree from the University of Colorado School of Nursing in 1972. She completed Squadron Officer School in 1973, Air Command and Staff College in 1974, and Air War College in 1977.

In January 1962 General Goodwin joined the Air Force and was assigned as a staff nurse with the obstetrical unit at Otis Air Force Base, Mass. While at Otis, she graduated from Flight Nurse School in May 1963. She was assigned as a clinic nurse and school health nurse, Naha Air Base, Okinawa, in November 1963. In July 1965 she became a clinic staff nurse at the USAF Hospital, Minot Air Force Base, N.D.

After receiving her undergraduate nursing degree from the University of Pennsylvania in 1968, General Goodwin was assigned as a flight nurse, training officer, and standardization and evaluation officer with the 2nd and 58th Aeromedical Evacuation squadrons, Rhein-Main Air Force Base, West Germany until 1971. Her next assignment was at the University of Colorado, where she received her graduate degree in August 1972.

General Goodwin served her first tour with the USAF Medical Center, Scott Air Force Base, Ill., as a charge nurse on the medical unit. In July 1973 she was assigned to Malcolm Grow USAF Medical Center, Andrews Air Force Base, MD., as clinical nurse specialist and charge nurse, prototype study. She became nursing practice coordinator, surgical units, in July 1974.

Upon completing Air War College in July 1977, General Goodwin was assigned as assistant chief nurse, USAF Regional Hospital Lakenheath, England. In July 1979 she was assigned as administrative staff officer, Office of the Chief, Air Force Nurse Corps, Bolling Air Force Base, D.C. The general then served as chairperson, Department of Nursing, David Grant USAF Medical Center, Travis Air Force Base, Calif., starting in July 1983. In October 1984 she became assistant for nursing services, Office of the Command Surgeon, Headquarters Military Airlift Command, Scott Air Force Base. She assumed her present duties in October 1988.

Her military decorations and awards include the Legion of Merit with one oak leaf cluster, Meritorious Service Medal with two oak leaf clusters, Air Force Commendation Medal, Air Force Outstanding Unit Award with one oak leaf cluster, Air Force Organizational Excellence Award, National Defense Service Medal, Air Force Overseas Ribbon-Long with two oak leaf clusters, Air Force Longevity Service Award Ribbon with five oak leaf clusters, and Air Force Training Ribbon.

The general is a member of the American Nurses Association; Aerospace Medical Association, Flight Nurse Section; Sigma Theta Tau; Association of Military Surgeons of the United States; Air Force Association; and Business and Professional Women's Organization. She was promoted to brigadier general Oct 1, 1988, with same date of rank.

NURSE ANESTHETISTS

Senator INOUE. Thank you very much, General.

In response to the critical shortage of nurse anesthetists, I submitted an amendment last year to increase funds for this specialty. But as you know, this has not been authorized yet, so the money is just lying around waiting to be used.

Having said that, I am not pleased, because that was just a band-aid and this problem is too immense to be treating with a band-aid.

NURSES PROMOTION PATH

I will be submitting questions to your Chiefs, who are sitting in back of you, and to the Secretary and to our new Secretary of Defense, asking them what, if any, justification there is to insist that nurses' promotions be held up for 3 to 5 years longer than other services. Why can we not take the cap off, as we have done for physicians? I want to know how they feel about this, in writing.

I also want to know why there is only one flag officer in the Active service and none in the Reserves. If nurses are going to be treated as professionals, then they should have the status symbols of professionalism. And I am going to ask the Department what, if any, justification they have for insisting on only one per nurse corps in the service and none for the Reserves.

So these are some of the questions I am going to be asking your Chiefs. Do you have any comments to make? General?

General GOODWIN. Sir, I might if I may correct you. We do in fact—my mobilization augmentee just retired and she was, in fact, a flag officer. So just to say that we do have one in the Nurse Corps.

Senator INOUE. You have one only?

General GOODWIN. In the Reserve, sir. You mentioned that there were none in the Reserve forces. There has been one in the Air Force.

Senator INOUE. Do you have any in the Reserve?

General ADAMS-ENDER. Yes, sir. Well, we have right now a colonel promotable—Dorothy Pocklington. She will soon be promoted to general officer.

Senator INOUE. But the Navy does not have one?

General ADAMS-ENDER. Yes; the Navy does not have one.

Admiral HALL. We have a request to reallocate two Medical Corps Reserve flag billets to one for the Nurse Corps and one for the Medical Service Corps.

Senator INOUE. Well, if it takes just money, you have got it. Any justification for limiting to just one in the service, the Active service?

Do you not think you should want another sister with a star?

General ADAMS-ENDER. I would not mind having some sisters, and some brothers too, sir. [Laughter.]

You see, 25 percent of the Army Nurse Corps is male. So I have to make sure that I am sensitive to that and that I talk about both female and male nurses.

I am not sure that I can tell you the justification for the limitation at this point in time. But I can tell you that I believe the time has come when we should indeed revisit that issue in terms of the numbers.

PROMOTION LIMITATIONS

Senator INOUE. Do you think there is any justification for the limits on promotions by keeping you in grade 3 to 5 years longer than other services? I believe that is the situation at the present time.

General GOODWIN. Sir, if I may, sir, our promotion system in the Air Force is such that our problems at this point would not be resolved specifically by eliminating the DOPMA cap, the DOPMA ceiling. We are working within the Air Force personnel system and have been somewhat successful in lifting some of our restrictions. I do not know that that will be an ongoing—or resolve our problems through the out years.

However, at this time we feel fairly optimistic that that is going to meet some of our problems, resolve some of those problems, and enable us to retain some of our well-qualified people.

Senator INOUE. Is that the same for the others?

General ADAMS-ENDER. Not so for the Army, sir. We do believe that an exemption to the field grade limitation would indeed be of particular help to us and would be of help to us primarily from the standpoint of providing individuals who come in, not only from the retention standpoint but from the recruitment standpoint, by providing those individuals who are coming in with being able to get higher grade whenever they come in.

We could retain the experience more from the promotion standpoint, and we could also ensure a steady flow of individuals who come in because of their ability to be recalled within the system.

So we do indeed believe that an exemption from that, from the DOPMA, would indeed be of assistance to us.

Admiral HALL. Yes, sir; we also need DOPMA relief, and it is three part. One, we would like to recall experienced nurses that we have in our Reserves back on active duty, and we really can—we run into problems if we bring them back, exacerbating our promotion problems.

We think that if you recruit someone, they really need a full career recognizing that ever-advancing levels of experience, and not have them chop off in midcareer. And then for retention among those that we have, we desperately need DOPMA relief, because we are feeling the impact and have for the last 3 years.

And under one selection board from lieutenant to lieutenant commander, we had 100 officers that were qualified that we could not promote. Of these 100 officers, most of them had between 9 and 13 years. All of them had a baccalaureate or higher education, and 96 percent, sir, were the professional nurses providing direct patient care.

So we certainly fully support DOPMA relief. And thank you, sir.

NURSING SCHOOL

Senator INOUE. What about a nursing school?

Admiral HALL. Can we sing in chorus; yes, sir? [Laughter.]

Senator INOUE. Do you have any plans? I was told that the services have a plan.

General ADAMS-ENDER. Yes, sir. What has happened to this point—and we started with the plan last July—the dean of the medical school at the Uniformed Services had part of his strategic plan to start a nursing school in that particular medical school.

And so by September we had put together a task force to review that issue. First we got together as the military nursing service chiefs and talked about the issues, basically. And we have an ongoing task force that is looking at that, and they are due to report out in May to the Surgeons General as to the feasibility.

And the feasibility, of course, has to do with the type of program, the types of students, because we feel that it would be to our advantage to be able to provide some upward mobility for some of the young corpsmen in the Army and in the Air Force and the Navy, to be able to come to that school if indeed they have had some prior general education courses.

And they are going to report out in May on that issue. They also are going to report out on location and a number of the other issues in terms of costs. But it looks very favorable, I believe, in terms of what they will say to the Surgeons General and their recommendation that we do indeed establish one.

But we all believe that it is a very good idea.

CONTRACT NURSES

Senator INOUE. Thank you very much.

I have been advised that 20 percent of the nurses in the Navy are contract nurses. Is that correct?

Admiral HALL. I have 3,000 nurses on active duty and I have 331 that are currently contracted. Those are coming into the civilian contracts. I am not too sure where the figure comes from, but I just got that number this morning, that under our civilian contracts we are currently employing 331.

Senator INOUE. What is the situation with the other services?

General GOODWIN. Sir, within the Air Force the bulk of our nurses, our military nurses, we hire less than 700 civilian nurses. At a few of our large facilities, we do have contracting for personal service contracts, where we will hire out or contract for approximately 30 civilian nurses a day.

General ADAMS-ENDER. We have approximately 280 nurses that we contract through various programs, one having to do with AIDS funding, the Army Medical Enhancement Program, the direct health care provider, and then the personal services contracts. We provide about 280 nurses within those particular programs.

I would just like to add that, much the same as the Surgeons General talked about before in terms of the physicians working next to other physicians who make three times the money as they do, it is a disincentive for Army nurses and for Department of Army civilian nurses to work next to these nurses who make sala-

ries that are twice or one and one-half, one and one-half to two times as much as they are making at the same time.

As a matter of fact, the Department of Army civilian nurses that are working very often leave the services, as I said in my basic statement, to return to the private sector, to join those particular agencies that get contracts with the Army to do this type of thing.

Senator INOUE. So it is not cost effective, nor is it good for the morale?

General ADAMS-ENDER. That is true, sir.

General GOODWIN. Another example of the competition is, while we have the number that are actually contracted is 331, the average number on board daily is 236. They cannot always even fill the full contract requirements, again because of the competition in the civilian sector to fill those.

Senator INOUE. Would you describe your nurse shortage and nurse retention problem as critical or serious, or what is it? Terminal?

Admiral HALL. Critical.

General GOODWIN. I would say it is serious. I think it is urgent that we address it now, however, because we do not have the flexibility within the military service to respond immediately to fluctuating work loads. And our great concern is that if it is not caught at this point in time, that it will take decades to recover what we have now.

And so it is for that reason that we certainly need your support at this time, sir.

General ADAMS-ENDER. I would echo the fact that it is serious, and the reason I would echo the fact that it is serious is because it looks as if the trend is the same as it is in the civilian sector. And that is that it is not going to get any better over time.

So that in order to be able to respond to the trends we see coming, I believe at this point in time it is serious and that we will indeed, if some actions are not taken, we will indeed have a critical problem within the next few years.

PATIENT CONTACTS

Senator INOUE. Doctors have contacts with their patients. Pentagon officials have almost no contact with your patients. You are the ones who spend almost all of your time in contact with patients. So if anyone knows anything about the quality of life or the quality of service or the satisfaction or dissatisfaction, it would be the nurses.

Would you say that our men and women and their dependents are satisfied with the medical care they are receiving and their dependents are receiving?

General ADAMS-ENDER. As you mentioned earlier, sir, with one of your comments, the comments that you have received from individuals who have had access to medical care within the military services, that they are usually very satisfied with the services, and that is my perception. They are usually very satisfied with the services.

However, they are very frustrated in many situations because of the amount of time that it takes for them to get services. And that is, of course, the access to care. But in the fixed facilities where

most of the nurses that we have are employed and do their jobs, the patient's frustration is much the same—the amount of time that it takes for nurses to be able to provide direct services to them. And they get frustrated when they have to wait for those services to come.

And, of course, when you are acutely ill—and we are seeing many more acutely ill patients through our facilities now—they indeed may have need for that service a lot earlier than they are able to get. And this is one of the things that really causes me to define the situation right now as serious, because I know that the length of time that has been required for those patients to be able to get care because of the work load that is on that nursing staff has increased over time and does indeed need to be looked at specifically because of the criticality of that care for those patients.

Senator INOUE. Thank you.

Admiral?

ACCESS TO CARE

Admiral Hall. In doing the site visits, the primary thing that I run across in dealing with the patients is their complaints about access to care, that once they get into the hospitals or into the clinics the quality of the care is satisfactory.

I think from the professional's standpoint, with the ever-increasing workloads and not being able to have the right ratio of staff to patients, that is a concern on the professional's side, to really make sure that when we run an ICU that we have adequate personnel to run it to meet every need of those patients.

So from the customer's standpoint, it is an access to care criticism and concern that we always have.

Thank you.

General GOODWIN. Sir, that holds true in the Air Force facilities as well. We do routine surveys of our beneficiaries, and the primary concern there is the access to care, the lack of appointment, availability of appointment. However, once they access the system the responses are overwhelmingly positive regarding the care that is provided.

Senator INOUE. Because of the time constraints, I will have to submit to you other questions that I have, and I hope you will respond to them.

I want to thank all of you for joining me this morning and participating in our hearings and contributing your time. Nurses, as I said, are very important to me.

For the past 20 years, I have always had a nurse intern on my staff. This year I have a military nurse, one of your nurses, on my staff. Next year maybe I will have a nurse from the Navy, and the following from the Air Force.

This committee will be spending two weeks in Europe and the Middle East. We will begin our journey this Saturday, and at every stop we will be visiting hospitals. So it might be well if you would alert your nurses that the bad boys are coming. [Laughter.]

We will be going to your Naples hospital to participate in the tearing down of that hospital so we can get a new one. [Laughter.]

And I can assure you that I will look long and hard to get the funds necessary to resolve your problem here. Now that I am chairman, I have been told that I have got certain perks around here, and I will exercise them.

So once again, ladies, I thank you very much. And I thank you, gentlemen, for assisting us.

SUBMITTED QUESTIONS

[The following questions were not asked at the hearing but were submitted for response for the record:]

QUESTIONS SUBMITTED BY SENATOR INOUE FOR DR. MAYER

PHYSICIAN PAY BONUS

For Fiscal Year 1989, the Congress added funds to provide retention bonus payments for military physicians. The Department was to develop a plan to distribute those funds to meet critical requirements. From all reports, the determination of recipients for these payments was controversial within the Pentagon, and generated consternation in the field among those who did not receive any bonus.

Question: As you look at ways to solve your recruitment and retention problems, what incentives best meet your needs, and what are your estimates for how much they will cost?

Answer: Recent surveys conducted by the Department as well as the General Accounting Office confirm that compensation is a key factor in the recruitment and retention of military physicians. For example, that survey showed that two thirds of the physicians responding agreed strongly that compensation is a major factor in their decision to make the Service a career, and that they are not satisfied with their current compensation levels. Further, over 90 percent felt strongly that the present compensation system is not effective in retaining physicians in the Service. Finally, 71 percent stated that a pay bonus would provide some inducement to remain in the military.

These statistics help support the Department's pay proposals, forwarded to the Congress late last year, to improve the special pays for physicians as a targeted incentive to improve their retention. On March 24, 1989, the Deputy Secretary of Defense extended eligibility for the Fiscal Year 1989 Medical Officer Retention Bonus (MORB) to specialists in Groups 6 and 7; all physician specialties are now eligible. As reflected in the report to Congress "Plan for the Implementation of the 1989 Medical Officer Retention Bonus," November 15, 1988, the estimated cost of the MORB is \$30 million, including Groups 6 and 7. However, it must be noted that this estimate is predicated on the number of physicians selecting the various multi-year options. Because there are no historical data against which such estimates can be derived, the Department's estimate has the potential of significant change.

Question: What are your retention goals for physicians in the military?

Answer: For military physicians in the Department as a whole, the initial retention goal is 57% at one year past initial obligation. Because of the multiple accession sources for military physicians as well as variations in Service requirements, additional refinement of retention goals is under development.

Question: What would you like to see the Congress do this year to support your retention and recruitment programs?

Answer: The Department's concept for compensation incentives to improve physician recruitment and retention is contained in the tentative 1990 long-term special pay plan submitted in the report to Congress on Armed Forces Health Professionals Special Pays, dated December 1, 1988. The Department's legislative proposal regarding this pay plan is being coordinated with the Office of Management and Budget for clearance with other concerned parts of the Administration prior to formal submission to the Congress.

Wartime Military Medical Mobilization

Question. What plans exist to utilize medical facilities available in Allied nations to provide care to U.S. military, civilian and dependent personnel in time of war?

Answer. The use of the assistance and resources of foreign nations to preposition U.S. medical materiel and to provide medical care for U.S. casualties as an alternative resource is considered in meeting our theater requirements, and the DoD uses these resources to the extent possible to obtain increased capability in our efforts to help reach the maximum requirements. Negotiation and management of Host Nation Support (HNS) arrangements are primarily a function and responsibility of the Chairman, Joint Chiefs of Staff and Theater Commanders.

Question. How will the U.S. compete for available space overseas with local requirements—for example in West Germany, where they will face a significant number of military and civilian casualties in a NATO war?

Answer. It is true that there will be significant allied military and civilian casualties in a NATO war. Because of this, all existing HNS agreements for rendering care are for interim periods only. In the United Kingdom (U.K.), for example, the agreement for Host Nation support hospital beds in wartime is for only a short interim period. These U.K. beds are for the purpose of allowing the U.S. a buffer until a sufficient number of the contingency hospitals can be made operational. The number of countries that may be candidates for provision of HNS is limited by political considerations, available resources, and the country's geographic location in relation to our operational requirements. With the combination of limited, predesignated host nation support, continued procurement and prepositioning overseas of our deployable medical systems, and efficient utilization of the aeromedical evacuation system to return casualties to the Continental United States, the Department will be better able to meet wartime requirements.

Question. In the competition for lift assets to get U.S. forces and equipment to Europe, the Pacific or Southwest Asia in a mobilization, how will you compete for the airlift and sealift to get there?

Answer. Competition for airlift will always be a concern. We continually make our requirements for transportation known during the allocation process for operation plan development. The Department's plans to utilize host nation support, preposition deployable medical systems overseas, and maximize the utilization of existing in-theater assets helps meet our early-on requirements when competition for lift resources will be highest.

Question. Are you satisfied with your priority ranking for airlift under the existing mobilization plans?

Answer. Like other logisticians, we would like to see an improved priority ranking for airlift of medical assets. Our medical planners participate fully in the airlift allocation planning process during operation plan development. With this coordination process, and our plans to preposition deployable medical systems overseas and maximize the utilization of existing in-theater assets, we approach our goal to provide adequate, yet austere, medical support to the operating forces. In addition, the development of a dedicated Civil Reserve Air Fleet aeromedical evacuation support system utilizing B-767 and MD-80 aircraft is well under way. The initial operating capability is now scheduled for November 1990 with the delivery of 26 B-767 medical shipsets. Full operating capability is anticipated to occur in late 1991. These dedicated aircraft will assist in the evacuation of patients and movement of medical supplies and personnel.

CHAMPUS Reform Initiative

Question: Dr. Mayer, I was dismayed earlier this year when it seemed that Foundation Health Corporation, the fiscal intermediary for the CHAMPUS Reform Initiative (CRI), was in financial difficulties and, further, that claims processing for CRI in both California and Hawaii was badly in arrears.

What specific actions was Foundation able to take to overcome its financial difficulties, and what assurance do you have that these difficulties won't recur?

Are both CHAMPUS standard and CHAMPUS Prime involved in the claims processing backlog?

How up-to-date is claims processing today?

How long will it take the backlog to be eliminated?

Can you give us an estimate of savings anticipated as a result of the CRI in FY 1989?

Answer: Beneficiary satisfaction appears high with the CHAMPUS Reform Initiative demonstration. Meetings DoD staff held with MTF commanders recently in the two-state region indicate strong support for the program. RAND reports that military physicians generally expect a positive effect from CRI.

Under the CRI, services to our people are being improved dramatically. There are more than 100 "health care finder" medical personnel available in 18 military hospitals and eight clinics throughout the two-state area. They assist beneficiaries and hospital personnel in locating the most appropriate source of care. We continue to receive positive feedback from both our beneficiaries and our MTF leaders on the success of this feature.

CHAMPUS Prime, an enrollment program, is available in nine of the 18 catchment areas. Since care and treatment is not always available when needed in the nearest military hospital or clinic, beneficiaries can enroll to receive any care needed in the civilian sector from an established health provider network. Unlike under regular CHAMPUS, Prime enrollees are now offered preventive services, such as annual physical exams, health education classes, and other "wellness" information. Enrollees pay considerably less for health care than under the Standard CHAMPUS program. For instance, most doctor office visits cost a PRIME enrollee \$5, compared to \$20 to \$30 under the standard program. Hospital stays and other medical services also cost significantly less for the CRI users. Through the first six months of operation, approximately 25,000 beneficiaries enrolled in CHAMPUS Prime, about twice the number projected for that time period. Enrollment continues to grow at the rate of almost 3,500 members per month systemwide.

The demonstration also introduces CHAMPUS Service Centers, staffed by registered nurses who deal with medical issues, and Beneficiary Service representatives, who help beneficiaries understand and use the program. The technology capability of the centers, with advanced telephone and computer systems, has clearly increased beneficiary access to information services. We are also in the process of expanding this unique information service feature to health care providers.

With the good news of enhanced health care services for our beneficiaries through option health plans, CHAMPUS Service Centers, health care finders, and reduced cost-shares, also comes some bad news. We have had seriously deficient claims payment practices as well as financial and management concerns with our project contractor. These issues were so serious that the Department considered not exercising the second contract option period which began February 1. However, intensive continuous review of contractor performance and resulting corrections caused us to conclude that the best course for our beneficiaries and for the government was for the demonstration project to proceed.

Despite continuing difficulties in claims payments, particularly for mental health providers, the Department

is pleased with the way contractor performance has improved to strengthen the claims processing operations.

During the first six months of operations both Blue Cross of Washington and Alaska (BCWA), the processor of Standard CHAMPUS claims, and Foundation Health Corporation, the processor of claims from members of the managed care provider network, encountered major claims processing problems. Because of this breach of contractual standards for performance of the claims processing function, the Department issued a cure notice and withheld \$76 million in payments for several months.

Problems with computer systems for the in-system claims created a substantial claims backlog for the managed care portion of the program. As a stopgap measure, and to ensure that network providers did not quit the program because of cash flow concerns, the contractor disbursed interim payments to 90 percent of these claims holders pending final processing of each claim. The contractor still must develop an information reporting system which will enable the government to evaluate the effectiveness of this extraordinary process.

Significant progress has been made in the past three months: out-of-system, Standard CHAMPUS claims processing by Blue Cross of Washington and Alaska increased by over 50 percent to over 27,000 per week in early April. The weekly output (115 percent of receipts) is more than adequate to meet contract requirements, once the backlog is retired. BCWA, which has received, by far, the bulk of the claims, has processed almost 90 percent of their net claims receipts and continues to show rapid improvement. They have now achieved full compliance with Standard CHAMPUS claims processing standards.

The processing of managed care claims increased six-fold over the last three months to almost 25,000 per week. For these in-system claims, Foundation Health Corporation contracted in January with Electronic Data Systems (EDS) to fulfill the managed care claims functions. EDS started right on schedule to process all in-system claims yesterday. The contractor now projects full compliance with managed care claims timeliness standards, and elimination of the claims backlog by June 15. Over 75 percent of claims received to date have been processed.

The deficiencies in claims processing and the contractor's management information system resulted in a lack of data to determine the overall effects of the two new health care options for CHAMPUS beneficiaries -- CHAMPUS Prime and Extra -- on utilization and costs, and to substantiate the impact of large discounts the contractor reports within the CRI provider networks. In addition, problems encountered with the claims processing systems limited the marketing effort to CHAMPUS beneficiaries and the utilization review and quality assurance programs designed to monitor the quality and appropriateness of care provided through CHAMPUS Prime and Extra. The claims processing delays did not appear to impair delivery of services during the first six months of operation.

Meetings held by DoD staff and the contractor recently in California with CHAMPUS providers and military personnel reinforced the strong support of military line leadership, local MTF commanders and CHAMPUS beneficiaries for CRI. Standard providers, particularly in the mental health area, remain frustrated and upset, as we are, about the delay in payments. We now have a special task force at BCWA headquarters that is sending overdue checks out to this special provider community. The contractor will be meeting again with the same providers and military leaders to receive quick feedback on the results of this effort.

We intend to hold these town meetings more frequently and routinely with providers and military leadership in the two-state area. We believe this feature of the demonstration helps spot problems much quicker than our current fiscal intermediary contracting routines.

CEO-level meetings with the subcontractors and quarterly meetings with military treatment facility commanders will be held to ensure a broader range and direct level of communication, with improved responsiveness in identifying and correcting deficiencies in a rapid, yet formal and satisfactory manner.

Several new management practices have been agreed to. New senior managers with significant government contracting, business management, and health insurance experience have been added. The new Vice Chairman of the Board and Chairman of the Board's Executive Committee is Earl Fowler, VADM, USN, Retired, the former commander of the Naval Sea Systems Command. The new Chief Executive Officer (CEO) for Foundation Health Corporation is Daniel Crowley from Blue Cross/Blue Shield of Ohio. The new President for the Government Division is Stuart Platt, RADM, USN, Retired, formerly Competition Advocate General for the U.S. Navy.

Significant contract modifications were secured to ensure greater overall protection of government funds. Contract payments are now tied more closely to the contractor's performance, and government funds are in restricted accounts. Merrill Lynch, the principal owner of Foundation, continues to provide strong financial support.

At the Department's request, The RAND Corporation has recently prepared an initial evaluation report. It discloses a continuing development through this "shake-down" period and the caution that "it would be premature and even irresponsible to assess CRI's effectiveness" at this point in the demonstration. The Department has filed with Congress recently a six-month report on the Reform Initiative which sets out in further detail the status of this project.

The Department has conducted, and will continue to conduct, intensive financial, management and system reviews of the contractor. This demonstration project is one of the Department's major initiatives to determine how

appropriate project comparisons. Other demonstration projects include a long list of Congressionally mandated activities, most of which are targeted to particular types of care or providers, such as chemical aversion therapy, chiropractic care, marriage and family therapy, home health care, biofeedback and others. Evaluation plans have been or are being developed for these Congressionally mandated projects, as well as several other ongoing, limited scope health care delivery demonstration projects initiated by DoD.

As the implementation and evaluation processes go forward on the three managed care demonstrations -- CRI, CAM, and FI-PPO -- a composite managed care model, incorporating the lessons learned and most advantageous features of each project, is expected to emerge.

Question: Could you tell us briefly what actions have been taken or are being taken to improve on the Department's ability to forecast CHAMPUS costs?

Answer: Historically, the Department's inability to budget accurately for CHAMPUS costs had resulted in severe turbulence in CHAMPUS claims processing and payments, not to mention frequent requirements for supplemental appropriations. DoD mounted an aggressive effort to improve forecasting of CHAMPUS costs through better definition of cost components, and refinements in our forecasting methodologies. The result is a big improvement in FY 1989.

Halfway through this fiscal year, CHAMPUS spending is on track with our projections. After the turbulence experienced between FY 1985 and 1987, sufficient funds were available to pay all claims processed in FY 1988, no unpaid claims were carried over into FY 1989, and no mid-year supplemental appropriation was required.

Project RESTORE

Question: Dr. Mayer, in your statement, you say emphatically that "the overriding factor in rising CHAMPUS costs continues to be workload coming out of the direct care system."

What programs are now in place to encourage patients to stay in the direct care system rather than going out into CHAMPUS? What are your plans for the future?

Has anyone been able to make an estimate of how much it will cost the Department of Defense to restore levels of medical services in Military Treatment Facilities sufficiently to have a meaningful impact on CHAMPUS costs?

Answer: The Department has a number of programs in place to enhance the level of services in medical treatment facilities (MTFs) and thereby reduce the reliance on the CHAMPUS program. These programs center on the Department's strategy of investment which builds on the notion of care in the direct care system being less expensive. The Department's investment strategies focus on Project RESTORE. Its principal components are the Partnership Program, the Alternate Use of CHAMPUS Funds Test and the Management Efficiencies Initiatives of each Military Service.

The Partnership Program supports MTF-provider agreements which allow civilian physicians and other providers to treat CHAMPUS patients in MTFs. There are now over 600 agreements in effect. Early evidence shows cost savings due to the negotiated discounts established in the provider agreements.

The Alternate Use of CHAMPUS Funds Test supports the limited use of CHAMPUS funds for MTF projects yielding a net savings to CHAMPUS. The test allows \$50 million per Service of CHAMPUS claims funds to be merged with other medical funding to enhance the efficiency and productivity of, and return CHAMPUS care to, the military treatment facility setting. Thus far, in FY 1989, there are 34 approved projects. Of these 34 total projects, 20 have been approved from the Army, one from the Navy, and 13 from the Air Force. These projects recapture a wide variety of high cost CHAMPUS workload, including over 8,200 admissions and 56,000 outpatient visits during their first year of operation. The investment costs are \$7.2 million in FY 1989, and \$20.1 million in one year from implementation, while recapturing \$10.6 million in CHAMPUS claims in FY 1989 and \$34.4 million in CHAMPUS claims within one year of implementation. A report requested by the Appropriations Committees was submitted to Congress in September, 1988.

Each of the Services has developed Management Efficiency Initiatives to reverse the shifting of workload from the direct care system to CHAMPUS. These initiatives include a broad range of contracting projects for services in military hospitals. This strategy has been expanded in the FY90/91 President's Budget with additional funding being added to the direct care system and the estimated savings being removed from the CHAMPUS portion of the budget. The Department's plans for the future include an evaluation of the cost-effectiveness of each of these RESTORE components and their continuation and expansion if cost-effectiveness is demonstrated. The review of the Partnership Program is underway with results expected in May, 1989. The Alternate Use Program is being jointly monitored by Health Affairs and the DoD Inspector General to ensure its cost-effectiveness. The results of this joint monitorship will be reported this Fall.

No additional "cost" to the Department is expected in our attempt to restore levels of services in MTFs and thereby make a meaningful impact on reducing CHAMPUS costs. In fact, the Department's strategies hinge on the notion that the amount of funding to enhance MTF services will be more than offset by reductions in the CHAMPUS requirement. As evidence, the FY 1990 and 1991 CHAMPUS budgets have already been reduced by \$252 and \$317 million respectively in anticipation of the success of the program.

CHAMPUS Demonstration Projects

Question: I know that the Department of Defense has a number of demonstration projects ongoing, many of them mandated by Congress.

Can you tell us which of the ones actually in operation now show most promise of reducing CHAMPUS costs in the future?

Would you provide for the record a list of ongoing CHAMPUS demonstration projects with an estimate of the savings they are expected to generate?

Answer: Congress has established a clear interest in reforming the delivery and financing of peacetime health care services under the Military Health Services System, especially CHAMPUS. One of the dimensions of this Congressional interest was shown in the 1983 enactment of the Department's health demonstration authority. This authority is quite flexible to improve "the quality, efficiency, convenience and cost effectiveness of providing health care services" to all categories of DoD beneficiaries. While this section lists the types of projects that may be used, it is clearly not an exhaustive list, and suggests wide parameters. In the 1987 Defense Authorization, the Congress again acted on demonstrations, this time to provide specific demonstration authority to conduct the CHAMPUS Reform Initiative, and it is under the parameters of that authority that the project currently proceeds. In the following year's authorization, the specific demonstration authority to conduct the catchment area management demonstration projects was enacted as well as that provision which identifies what has become known as the "Kyl Amendment" projects. Seven additional demonstration projects, some already being implemented at that time, were cited to be conducted and evaluated for potential incorporation into the Military Health Services System. A further requirement was included in the House Armed Services Committee (HASC) Report on the proposed FY89 Defense Authorization Act to perform a comprehensive evaluation of all projects identified in the Kyl amendment to compare lessons learned from one project to lessons learned from other projects.

The agenda focuses on three alternate models of managed care initiatives, capitalizing on private industry success with the containment of costs through managed care. These are the CHAMPUS Reform Initiative, Catchment Area Management and the Fiscal Intermediary-Preferred Provider Organization project. The Department anticipates that, as experience is gained and lessons learned, there will emerge a composite managed care model, pulling from each project its most advantageous features. The RAND Corporation will be conducting the evaluation of these three projects. These three projects are:

- o An at-risk contract management model -- the CHAMPUS Reform Initiative (CRI) -- in which managed care activities are coupled with substantial benefits improvements under large contracts that place the contractor financially at-risk. The project is in place in California and Hawaii.

- o A decentralized military management model -- the Catchment Area Management (CAM) project -- in which local military hospital commanders are made responsible for implementing managed care activities for CHAMPUS in the hospital's catchment area. Five project sites are now in various stages of planning.

- o A fiscal intermediary enhanced management model -- the Fiscal Intermediary Preferred Provider Organization (FI-PPO) project -- in which CHAMPUS Fiscal Intermediary contracts are enhanced with new managed care responsibilities. This project is operating in Florida and Georgia, with a second site anticipated in FY-89.

All three of these managed care demonstrations are subjects of very thorough evaluations being conducted for DoD by The RAND Corporation.

In addition to these three major managed care demonstration projects, DoD is conducting a large number of other demonstrations. These include three previously operating activities made part of the 1987 "Kyl Amendment" on demonstrations: the Fort Drum project, the Tidewater Contract Provider Agreement for mental health services, and PRIMUS/NAVCARE clinics. Evaluation plans have been developed for these projects, which will permit the managed care delivery and financing of health care services can best help the military health care system and its beneficiaries. We plan to provide Congress a supplemental report in June on the status of this demonstration. We remain hopeful that results will show net positive effects of this dynamic reform initiative.

QUESTION SUBMITTED BY SENATOR BYRD FOR DR. MAYER

UP OR OUT PROMOTION POLICY

Question: It seems incomprehensible that the Services would continue to force out highly motivated, experienced, health care professionals due to the "Up or Out" promotion policy, and then have to recruit replacements out of the civilian sector who may not be nearly so motivated, experienced, or competent. I am advised that this "Up or Out" policy has been more stringently applied in the past five years or so, (for example, with regard to Navy Reserve officers on active duty) when compared to previous years and that this has contributed to the deterioration of medical care in the Navy and elsewhere in the Services. Please recount the history of this policy and comment.

Answer: The "Up or Out" promotion policy was first instituted in 1916 and was codified in the Officer Personnel Act of 1947. The Defense Officer Personnel Management Act (DOPMA), enacted in 1980, reaffirmed and simplified the "Up or Out" statutes with one set of provisions. These statutes are an integral part of the officer management system designed to maintain an officer corps with the proper level of experience and maturity within a fixed end-strength, while offering officers reasonable career expectations. The current officer management system has evolved over time to overcome the painful lessons chronicled in American military history, when military leaders were labeled unprepared, unfit, and unwilling to assume their designated leadership roles due to excessive tenure and attendant promotion stagnation.

Coupled with other loss management tools (i.e., statutory retirement, selective early retirement, resignations, etc.), the "Up or Out" policy provides controls that can be used to shape the force and enable a continuous flow of young officers into the Armed Forces. It also ensures that the best qualified officers are given the opportunity for challenging leadership positions, thereby enhancing the morale and retention of the entire officer corps.

The officer management statutes and policies are not absolute and do provide the flexibility necessary to deal with problems in specific communities of officers, such as health care professionals. For example, while the "Up or Out" statutes do apply to health care professionals, management actions can and are taken to minimize the numbers that are involuntarily separated when shortages exist. These include continuing officers who are passed over for promotion and increasing promotion opportunity. Evidence of these management actions is seen in the following statistics. In 1988, only three qualified physicians, not selected for promotion, were involuntarily separated, and promotion opportunity for physicians in 1988 is listed below (As a benchmark, DOPMA promotion opportunity guidelines are listed in parentheses):

	1988 Physicians Promotion Opportunity		
	<u>0-6 (50%)</u>	<u>0-5 (70%)</u>	<u>0-4 (80%)</u>
Army	131%	78%	98%
Navy	71%	87%	102%
Air Force	117%	98%	99%

Note: Promotion opportunity is calculated by dividing the total number selected (all zones--above, in, and below) by the total in-zone, thus enabling opportunity higher than 100 percent.

QUESTIONS SUBMITTED BY SENATOR SASSER FOR DR. MAYER

DISABLED MILITARY RETIREES

Question: What percentage of disabled military retirees have disabilities resulting from inadequate medical attention or substandard care in military hospitals as opposed to disabling injuries occurring while on duty?

Answer: The Department does not maintain statistics on disability retirees who were so categorized because of substandard medical care, so we cannot answer the question. However, a crude estimate made on the basis of claims filed for the last 2 fiscal years in relation to the number of disability retirees for those years suggests that the proportion is probably well under 2 percent.

Quality Assurance

Question: What percentage of all the claims filed through administrative channels are based on allegations of negligent or inadequate care, and what percentage of those claims relate to the most frequently filed areas (e.g. cardiology, pre-natal care)?

Answer: Risk management data collection and analysis address only those claims alleging some performance inadequacy. Early analysis of claims disposition data for 1988 reveals that 52.7 percent were denied, 19.9 percent were settled administratively, and 27.4 percent were settled by litigation. Despite allegations to the contrary, over 50 percent of cases did meet acceptable standards of care, and in another analysis, 48.9 percent of claims were determined to be without merit. For perspective, the residual, based on available figures to date, represents less than 1 per 10,000 patient admissions, or approximately 1 per 600,000 patient encounters.

22.6 percent of submitted claims involved OB/GYN, 22.6 percent involved surgery, and 10.7 percent involved internal medicine. Presented another way, 50 percent involved diagnosis or treatment, 23 percent involved invasive procedures, and 13 percent involved obstetrics. While these data are preliminary, risk management activities within the military health system are rapidly becoming more comprehensive and refined. We expect that such improvement will continue to be reflected in documented experience.

Question: What has been done during the last several years to improve the standard of health care which is provided in the military?

Answer: In addition to efforts to increase available military health care system resources (personnel, money, equipment, facilities) in an effective fashion, we have implemented a variety of initiatives to enhance the quality of medical care provided in the military. These initiatives include:

- (a) improvement of the regulatory environment within which the military health care system is operated. The following DoD Directives which have been implemented in recent years convey useful perspective:

DoD Directive 6025.1, Standards for DoD Health Care Provider Performance (April 19, 1983)

DoD Directive 6025.9, Patient's Bill of Rights and Responsibilities (August 20, 1987)

DoD Directive 6025.11, DoD Health Care Provider Credentials Review and Clinical Privileging (May 20, 1988)

DoD Directive 6025.13, DoD Medical Quality Assurance (November 17, 1988)

DoD Directive 6025.6, Licensure of DoD Health Care Personnel (June 6, 1988);

- b) the implementation of the Civilian External Peer Review Program, to assess the clinical activities of the military medical system world-wide;
- (c) enhancement of data collection, automation support, and communication to integrate better the management of allocated resources and the quality of patient experience. These include the establishment of the Tri-Service committees for quality assurance, medical records, and risk management; and, major automation initiatives perhaps best exemplified by the Automated Quality of Care Evaluation Support System (AQCESS) and the Composite Health Care System (CHCS);
- (d) administrative areas such as, automation initiatives, efforts to develop and implement a Diagnostic Related Groups Management System, and the revision of manpower staffing standards.

In summary, during the past six years, virtually all aspects of the military health care system have been submitted to a careful reassessment and refinement designed to structure sustained improvement in management and performance.

COMPENSATION FOR INJURIES

Question: What can be done, in terms of compensation, for those injuries which do not result in a physical disability which would prevent the service man or woman from performing his or her job, but which do result in a tragic loss, such as sterility? I understand these are currently non-compensatory and there is no recourse for personnel subjected to this kind of loss.

Answer: The only way that such a tragic loss can be recognized in terms of compensation is if the member involved remained in

service until eligible for retirement. Some degree of disability for such an injury could then be claimed so far as disability retired pay is concerned. However, should the medical authorities agree beforehand that there is some degree of disability related to the injury in question, the Service member could be placed on a temporary disability retired list (at 50 percent of pay) even prior to retirement until such degree of disability is determined to be either temporary, in which case the member would be returned to active duty, or permanent, in which case the member would be placed on the permanent disability retired list.

Administrative Support

QUESTION: I have received numerous complaints from constituents regarding the treatment they receive in trying to make appointments, while waiting to see a physician, and while trying to locate their records. I have also been informed that many doctors are frustrated by the amount of paperwork they must do because support personnel can not or will not perform their duties adequately. What is being done currently, and what more can be done, to eliminate these problems?

ANSWER: OASD(HA) recognizes that there is a serious administrative support problem in the Military Healthcare System. The shortage of administrative personnel is presently being addressed by the development of Joint Healthcare Manpower Standards. The standards are to provide a uniform system for determining peacetime healthcare manpower requirements for operating fixed medical treatment facilities. To date, 25 standards have been developed and are currently being reviewed prior to publication. They will increase the support to physician ratio in all clinical areas and have much potential for future staffing improvements. These standards are based on a performance level which can be modified to respond to changing practice modes. It is our intent to publish the Joint Healthcare Manpower Standards for use in the planning and programming of human resources for all fixed medical and dental treatment facilities.

Co-payment for Medical Care

Question: My constituents are very concerned about a proposal that retirees, their dependents, and dependents of active-duty military personnel be required to co-pay for the medical treatment received in military health care facilities. Given the income of many who fall into these groups, and the implied contract of free medical care for retirees and their dependents, this would create a hardship on many military families as well as even more frustration with a system which has been eroding benefits for the past twenty years.

Answer: The FY 1990/1991 President's Budget currently before the Congress proposes a two year pilot program to introduce co-payments in the provision of health care to non-active duty beneficiaries in several geographic areas. Co-payments are to be consistent with those required in other federal programs including Veterans Administration programs. Families of junior enlisted personnel would be exempt. The budget calls for establishment of an Advisory Panel whose members will include medical experts from outside the government. The panel is to make recommendations on the design of the pilot program.

QUESTION SUBMITTED BY SENATOR BUMPERS FOR DR. MAYER

DRUG AND ALCOHOL ABUSE

QUESTION: Dr. Mayer, I commend the Department's efforts to fully inform our military personnel about the consequences of smoking and alcohol abuse. Have you seen any medical impact on this in terms of the demand for routine medical service by the military population?

ANSWER: We do not have enough specific data to give a definitive response to this. We do know, from our worldwide surveys, that heavy drinking appears to have declined for the first time in 1988, to a level of 8.2 percent, with an additional 23.5 percent reporting moderate to heavy use. Alcohol dependence is reported at a level of 6.4 percent in 1988. Figures from the 1985 Survey indicated 4.9 percent reported one or more occurrences due to drinking of: personal injury in an accident, an accident injuring others, or an illness that kept them from duty for one week or longer. Unfortunately, this measure is not available for 1988. Smoking is down from 51.0 percent in 1980 to 40.9 percent in 1988. Heavy smoking is down from 34.2 percent to 22.7 percent in the same period.

Many of the associated morbidities and sequelae of smoking and drinking alcohol are cumulative in nature and tend to show up less in our active duty population than in those who have been separated or retired. The Department of Veterans Affairs has a high incidence of upper respiratory and alcohol-related conditions among its treatment population. We also doubtless suffer from the same problem as the civilian community in the large number of patients who have an undiagnosed alcohol or smoking-related condition. Though we do not have data of the amount or specificity I would wish, it is my opinion that we have begun to make progress in these two areas but we still have a long way to go in making significant headway with these two pervasive and destructive problems before we see the savings to our military medical systems that we can and should achieve.

QUESTIONS SUBMITTED BY SENATOR D'AMATO FOR DR. MAYER

Uniformed Services Treatment Facilities (USTFs)

Question: Dr. Mayer, my strong support for the Uniformed Services Treatment Facility (USTF) program you administer, and especially for Bayley Seton Hospital, the USTF on Staten Island only 150 yards from the New Surface Action Group Homeport, is not news to you. Even though Congress dealt with this issue only a few months ago when it extended the USTF program at least until 1991, I believe it is appropriate to raise some of my concerns again.

One of the concerns I hear expressed most often is the frequency with which the Agreements between DoD and the USTF's change. This constant altering of reimbursement terms and mechanisms inhibits the long term planning so important to the maintenance of quality health care. What progress is the DoD making toward stabilizing these Agreements and instituting long-term contracts with the USTF's?

Answer: Pursuant to the direction of the Congress in the FY 1987 Defense Appropriations Act, the Department negotiated fixed amount payment mechanisms (similar to the flat rate mechanism negotiated in 1984 with the Pacific Medical Center) with all of the Uniformed Services Treatment Facilities. Each of those agreements was signed in early 1987 and effective with the beginning of Fiscal Year 1987 on October 1, 1986. Those agreements have remained stable and essentially unchanged, since that time. In fact, the only changes which have taken place, have occurred at the request of the USTF's themselves. For example, in June of 1987, Bayley Seton Hospital requested their agreement be changed to remove inpatient care for non-active duty beneficiaries from the list of covered services. As a result of their request, the Department agreed to changes in the agreement which provided for inpatient and outpatient care for active duty personnel, and outpatient care only for non-active duty personnel. The payment mechanism resulting from that list of services required the Government to pay Bayley Seton Hospital at the full annual market rate for unduplicated annual users who are active duty beneficiaries and at 60 percent of the annual market rate for non-active duty users. This distinction was made because the non-active duty users only receive outpatient care under the terms of the agreement.

We just recently completed a second round of renegotiations on their agreement to adjust the payment rate for care to non-active duty beneficiaries from 60 percent to 75 percent of the annual market rate. We believe this adjustment more nearly reflects the costs required to care for Uniformed Services beneficiaries who are older and require more expensive medical care. This adjustment was needed because the Federal Employees Health Benefits Program annual premium, which serves as the basis for computing the annual market rate for the USTF program, is based on a working population, where many of our beneficiaries are no longer in the active work force and some are eligible for Medicare.

We support stabilized agreements because they better enable us to budget for program costs when we can project what our needs will be in the future. We feel the current basic agreement structure meets our needs and the needs of the USTF's for stability.

Question: A second concern, which I hear from USTF beneficiaries, has to do with which services are to be covered under these agreements. What are your plans regarding increases in USTF reimbursements so that dental care and non-prescription drugs can be added to the package of services USTF's provide the program's beneficiaries?

Answer: The goal of the Department concerning the services provided in the USTF agreements is that those services be consistent with the benefits available to categories of beneficiaries under the direct care system and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Dental care for dependents of active duty and dependents of retired beneficiaries is not available under CHAMPUS, except for the care of an emergency or as directly related to certain medical conditions. Dental care is available to dependents of active duty and retired beneficiaries in the direct care system on a space available basis. When the USTF's were transferred from the Public Health Service to their present status, dental care was provided to all beneficiaries.

As part of the cost reductions mandated by the Congress in 1987, dental care was restricted to active duty members due to resource limitations. Also, non-prescription drugs were removed from the list of covered services at the same time, due to cost reductions. The Department has no plans to reinstitute either dental care or non-prescription drugs to the list of covered services for the USTF agreements.

Question: As you know, the USTF's are now reimbursed by DoD using an HMO model. In other words, the USTF's receive a set fee per unduplicated user regardless of the services provided. Unduplicated users include only those beneficiaries who actually receive services in a given year, not those eligible users, whether they actually receive services or not. This distinction results in a severe economic squeeze for the USTF's. At least one of the USTF's, Bayley Seton (which, I might point out, is reimbursed at a lower percentage level than are other USTF's), recently proposed undertaking an informational campaign at its own expense to educate eligible beneficiaries about the benefits of the USTF program to which they are entitled. As part of the educational campaign, Bayley Seton would enroll these beneficiaries in the program, just as an HMO enrolls its members. Bayley Seton's reimbursement would then be based on its enrollment, rather than on the currently used unduplicated user concept. I think such a program aimed at educating potential USTF beneficiaries about the program's benefits

is an excellent idea. What is your opinion? Will you work with Bayley Seton toward setting up such a program?

Answer: The concept of the unduplicated annual user was developed by the Government and accepted by the USTF's, during the negotiations of fixed price agreements. An unduplicated annual user is counted whenever an eligible beneficiary receives care in a USTF for the first time in a calendar year. The unduplicated annual user is analogous to the health maintenance organization enrollee with the difference addressing the issue of the highly mobile nature of the military or Uniformed Services family who is subject to a move anytime during the year, either in a temporary or permanent status.

We believe the analogy between the unduplicated annual user and the enrollee is a strong one. While it is true the user count is not established until the beneficiary receives care, the general concept of some patients receiving minimal amounts of care and others receiving larger amounts of care holds for users, as well as for enrollees. So, the amount of money paid for each user covers all users' care regardless of whether the amount of care received is large or small during the year. Also, it should be noted that users are counted all year long and that some users do not show up until the last month of the year. They are counted just as a user who is first treated in the first month of the year.

We have not found that the distinction between unduplicated annual users and enrollees is significant enough to cause a severe economic squeeze for the USTF's. To the contrary, what has actually occurred, and the Bayley Seton Hospital experience is a case in point, is the annual market rate based on the Federal Employees Health Benefits Program annual premium did not fully address the type of care being provided to Uniformed Services beneficiaries. The reason for this disparity is that the Federal Employees Health Benefits Program annual premium is based on a working population while Uniformed Services beneficiaries not only include that population, but an older population, many of whom are 65 years of age and older.

We recognized this fact and agreed to increase the reimbursement to the Bayley Seton Hospital for non-active duty beneficiary unduplicated annual users who receive only outpatient care from the previous 60 percent of the annual market rate to a new percentage of 75 percent of the annual market rate. Both Bayley Seton Hospital and the Government believe this adjustment more accurately reflects the cost incurred in caring for the Uniformed Services beneficiaries. I would point out again the reimbursement structure for the Bayley Seton Hospital is a two tier structure with the full annual market rate paid for active duty unduplicated annual users who receive both inpatient and outpatient care, and a reduced rate for non-active duty unduplicated annual users who receive only outpatient care. The Bayley Seton Hospital has withdrawn its proposal to enroll all eligible beneficiaries based on the new payment mechanism agreement recently negotiated.

DRUG AND ALCOHOL ABUSE

QUESTION: The Defense Department now conducts random, mandatory drug testing for all uniformed personnel and civilians in sensitive positions. Please tell the Committee what effect this has had on drug use in the military and in your work force.

ANSWER: Drug use reported by military personnel has steadily declined since 1980 when the first Worldwide Survey of Alcohol and Nonmedical Drug Use Among Military Personnel was conducted. From a high of 27.6 percent of all military personnel reporting drug use during the past 30 days in 1980, prevalence declined to 19.0 percent in 1982, 8.9 percent in 1985, and 4.8 percent in 1988. While there were a number of elements that contributed to this continuing decline, I believe that the deterrent effect of random drug testing was a major factor. For the civilian work force, we do not have similar trend data. A Worldwide Survey on Nonmedical Drug and Alcohol Use among Civilian Personnel was conducted in 1983. At that time, 4 percent of the respondents had used drugs in the prior 30 days. The Department of the Army is the only Department of Defense component which has been testing for a sufficient time period to accumulate data. Of 9,588 Army civilians in sensitive positions who were given random tests in FY87, 59 tested positive. This represents 0.6 percent of the tested population. In FY88, 44 of 7,688 tested were positive, again 0.6 percent. The other Services and the Defense Agencies have only recently begun their civilian testing programs.

QUESTION: Please describe for the Committee your programs for drug education and treatment.

ANSWER: Department of Defense Instruction (DoDI) 1010.5, "Education and Training in Alcohol and Drug Abuse Prevention", provides for alcohol and drug abuse education of military personnel at initial entry, permanent change of station, during professional or military education, and after an alcohol or drug related incident. There are different levels of intensity, content and scope for various specified groups (e.g., leaders [E-5 through E-9 and officers], health care professionals, and alcohol and drug program staff). Civilians are given similar education units. Education is mandated in DoD Dependent Schools for students in grades 1 through 12, and is offered on a voluntary basis to family members to the extent feasible.

Rehabilitation programs are structured to offer three levels of intensity, depending on the perceived needs of the individual Service member. The determination

as to which level of rehabilitation is appropriate is made by an individual's commander, based partly on a clinical assessment of the severity of the drug use or dependence. The first level of response is a structured education/awareness program designed for those personnel who appear to have had minimal involvement with drugs. The next resource is nonresidential counseling and rehabilitation. This is a program for individuals who have a pattern of abuse and who need some degree of therapeutic intervention beyond education and awareness. The nonresidential programs are available on most military installations of any size, and consist mainly of counselors who provide individual and group counseling. The third - and most intensive - is residential treatment, which is designed for alcohol and drug dependent individuals. These programs are all hospital based, with the exception of four large, freestanding programs operated by the Navy. All are abstinence oriented, multidisciplinary programs based on a disease model of addictions. They are strongly rooted in the twelve step philosophy of Alcoholics Anonymous and Narcotics Anonymous. The length of stay is generally four or six weeks, with variations to meet individual needs and situations. Both nonresidential and residential treatment are followed by one year's monitoring and aftercare.

Question: Do you think that Defense Department developed anti-drug programs could be adapted for use in the civilian community?

Answer: I believe the civilian community could benefit greatly from our anti-drug abuse program. The essential ingredient of our approach is the unequivocal message from every level of command starting with the Secretary of Defense that drug abuse will not be tolerated. This does not necessarily translate, as some have thought, to automatic separation for drug abuse; it does mean, however, that we will not permit drug abuse to go unchallenged. Command will use effectively all available tools to eliminate drug abuse from the military - education about the dangers of drug abuse and about our policy of nontolerance; detection, especially through random urinalysis; treatment for those who show potential for restoration to useful duty; and, full cooperation with law enforcement agencies. And equally important, drug dependence is not recognized as an excuse for illicit or improper behavior. Civilian organizations will have to tailor our approach to their own particular needs and circumstances, of course, but I think every aspect of the DoD experience in confronting drug abuse has some applicability.

QUESTION: Do you plan to make contact with the Director of Drug Control, Secretary Bennett, and share with him those programs of yours that work?

ANSWER: Both my office and the DoD Office of Drug Policy and Enforcement have had ongoing involvement with the former National Drug Policy Board. A senior member of my staff has been active on the Treatment Committee and the Demand Reduction Task Force of that body. We have participated in the development of the National Drug Strategy, with particular regard to the policies and programs of DoD, and have been instrumental in developing issue papers for Mr. Bennett to consider. We have also worked with the Office of Management and Budget to keep that office apprised of the variety and level of effort in DoD's drug prevention programs.

QUESTIONS SUBMITTED BY SENATOR INOUE FOR GENERAL LEDFORD

CHAMPUS AND DIRECT HEALTH CARE COST

QUESTION. Dr. Mayer's statement made reference to "Project Restore," an initiative to retain more of the medical treatment for DoD beneficiaries in the direct care system. The belief is that these services can be provided in a more cost effective basis through military hospitals and clinics, both for the government, and the patients. Do you agree that bringing more of the workload back from CHAMPUS into military treatment facilities could produce a savings? Do you have an estimate of what each additional dollar apportioned to direct care could save in terms of CHAMPUS costs?

ANSWER. We are convinced that we can do more workload in our own facilities at a savings over CHAMPUS. Not all CHAMPUS can be recovered, but we believe that with adequate resources and with minor changes in some regulations we can substantially increase our capability to the extent of health care demand within our communities and the physical capacity of our health care facilities. Comparing the full costs of producing care within the U.S. Army Health Services Command and the cost to the government of CHAMPUS in Fiscal Year 1987, it costs an average of \$1.41 to provide the care with CHAMPUS which can be provided for \$1.00 within our facilities. This is, of course, an average. Experience at specific locations and for specific medical services may be more or less.

QUESTION. Absent funding constraints, how much additional funding could the direct system absorb in fiscal year 1990, and what offset from CHAMPUS would you anticipate?

ANSWER. Assuming the funds to be available at the beginning of the fiscal year, the Army could absorb an additional \$61 million in fiscal year 1990. If we were to be relatively certain of this type of increase and could begin preparing for it earlier than the beginning of the fiscal year we would expect a reduction of \$73 million in CHAMPUS for fiscal year 1990. Some of the expected savings will not be realized until the following year since there is some delay from the provision of CHAMPUS care to the presentation of claims to the government.

QUESTION. In what areas would you focus additional funding in the military medical system?

ANSWER. Additional funding in the military medical system is being focused on establishing a CHAMPUS management structure at each military medical treatment facility (MTF) to enable the MTF commander to better control the total need for health care within his catchment area (roughly defined as a 40 mile radius around the MTF, bounded by zip codes). Establishing cost effective agreements, managing catchment area CHAMPUS budgets, negotiating and monitoring contracts with civilian health care providers, as well as providing assistance to beneficiaries in selecting the most cost effective sources of care would be accomplished by this management team. The desired outcome of this initiative is to adequately resource the command to actively manage the CHAMPUS program at the local level, thus

reduce CHAMPUS expenditures. This effort involves a projected FY89 budget of over \$800M in Army CHAMPUS dollars and the intention to manage/control expenditures at the level where it will make the most sense; the individual catchment area.

QUESTION. In each of your commands, which facilities face the greatest needs?

ANSWER. The top 10 facilities which face the greatest need in U.S. Army Health Services Command (HSC) are:

- Fort Bragg
- Fort Carson
- Fort Hood
- Tripler AMC
- Fort Belvoir
- Fort Stewart
- Fort Knox
- Fort Lewis
- Fort Dix
- Fort Devens

In 7th Medical Command, Frankfurt ARMC, Landstuhl ARMC and the Nuernburg MEDDAC have great needs.

PRODUCTIVITY FOR HEALTH CARE PROVIDERS

QUESTION. It is my understanding that a common complaint reported from military medical personnel is their frustration over the non-patient treatment duties they face. The time physicians, nurses, and other professionals spend outside their direct mission subtracts from the number of patients that can be treated, and their own job satisfaction. What efforts are underway to increase the productivity of your health care providers in military treatment facilities?

ANSWER. Efforts underway to increase productivity basically fall into three categories--near term, mid term and long term efforts. In the near term, the Army Medical Department has initiated the Army Medical Enhancement Program to provide ancillary support (nurses and technicians) and medical administrative personnel to provide more responsive and efficient health care to soldiers and their families by increasing the productivity of our direct care providers. Mid term and long term efforts include new construction at approved sites which will consolidate functions previously separated (i.e. Brooke Army Medical Center) and Composite Health Care System (CHCS) which will reduce redundant medical information and systematically manages patient treatment information.

QUESTION. What are your current shortfalls in administrative and support personnel in military medical facilities?

ANSWER. The current shortfall is 4,641 in administrative and support personnel (non-nursing).

QUESTION. Are there any initiatives underway to address the problem of physicians and nurses losing time from their primary duties to perform administrative functions?

ANSWER. The Army Medical Enhancement Program is the primary initiative to increase the staffing for administrative and ancillary support personnel. In fiscal year 1989, the program will increase 150 appointment clerks and 243 medical technicians. In fiscal year 1990, the program will further increase 40 appointments clerks, 163 medical administrative personnel, and 294 medical technicians. As a result of savings generated by the Vander Schaff study, the AMEDD will also increase 48 medical administrative personnel.

QUESTIONS SUBMITTED BY SENATOR BYRD FOR GENERAL LEDFORD

HEALTH PROGRAMS (BASE CLOSURE ISSUES & NURSING PROGRAMS)

QUESTION. The Commission on Base Realignment and Closure submitted its list of bases to Congress. Included in this list of proposed closings are medical facilities (that are a part of the bases listed) that provide health care to individuals who have retired near these bases and become dependent upon these services. What actions does the Department of Defense intend to take to continue providing these health care services to these retirees?

ANSWER. Retired beneficiaries residing in Army medical catchment areas will be required to obtain health care at other service medical facilities in the area or through CHAMPUS. When Letterman Army Medical Center (LAMC) closes retired personnel and their dependents may seek care at the Navy Hospital Oakland or the Air Force hospital at Travis Air Force Base. In the event that space is not available at these facilities retired personnel will be required to use CHAMPUS.

In the Fort Dix area retired beneficiaries may seek care at the Fort Dix hospital. Another option would be the Veterans Hospital in Philadelphia through the joint venture that is currently being negotiated between the Department of the Navy and the Veterans Administration. Personnel who are not accommodated at these locations will be required to use CHAMPUS.

The closure of the medical clinic at Fort Sheridan will require all retired beneficiaries to use CHAMPUS.

QUESTION. Are whatever substitute health care services contemplated by the services comparable in terms of price and quality of care?

ANSWER. The health care received at medical facilities of the other Services will be the same quality and cost as in Army facilities. The care received in civilian medical facilities through CHAMPUS will be of the same quality however will cost more. The government will pay more for the services provided and the costs to the beneficiary will be greater due to the CHAMPUS copayment.

Providing Health Services to Retirees at Base Closure Sites - #1

QUESTION: The Commission on Base Realignment and Closure submitted its list of bases to Congress. Included on this list of proposed closings are medical facilities (that are part of the bases listed) that provide health care to individuals who have retired near these bases and become dependent upon these services. What actions does the Department of Defense intend to take to continue providing these health care services to these retirees?

ANSWER: The Air Force Medical Service operates medical treatment facilities primarily to support the active duty personnel and the wartime mission associated with each specific base. When a base closes, wartime missions are realigned to other bases, and the

military medical manpower are relocated to support that realigned mission.

Care for retirees is on a "space available" basis. Funding limitations do not sufficiently permit programming for retiree care.

THE PRICE AND QUALITY OF SUBSTITUTE HEALTH CARE SERVICES

QUESTION: Are the substitute health care services contemplated by the services comparable in terms of price and quality of care?

ANSWER: In terms of the cost of providing health care in AF medical facilities compared to purchasing health care in the private sector there is a price difference. In comparing fiscal year 1987 costs, it cost the AF an average of \$2,264 for each admission in a AF hospital while it cost the Government \$4,475 for each admission under the CHAMPUS Program. In addressing the quality of care, both the AF and civilian systems provide acceptable quality of care, although AF care in many areas is of higher quality.

HEALTH PROGRAMS (Base Closure Issues & Nursing Programs)

Question: Currently the armed services are experiencing a shortage of trained and experienced nurses (as are health care providers in the civilian sector). The situation in the armed services is being complicated by the current structure of the promotion system in the Nurse Corps. Under the "Up or Out" promotion policy, many qualified, experienced, and dedicated nurses are being forced out of the armed services for a lack of promotion slots. The same is true with regard to physicians. The FY 1989 Department of Defense Authorization (Act) called for a Demonstration Project for attracting nurses into the active and reserve military services. "In order to help improve nurse staffing levels, the (Armed Services) Committee directed the Secretary of Defense to implement a demonstration project establishing a cooperative effort between the nursing corps of the military services and post-secondary educational institutions with nursing programs for the purpose of recruiting additional nurses into active and reserve services." Under such a demonstration, the Secretary is to consider the feasibility of sharing the costs of undergraduate training in return for a military service commitment on the part of the individual. Given the current shortage of nurses, would such a program be cost effective?

Answer: We are working with the Navy to conduct the demonstration project within the resources available to the Department. Upon the project's completion, we will be able to assess the cost effectiveness of such a program. The results of the demonstration project will be reported to the Congress following its completion.

QUESTION: What Can be done to address the problem of mid-career nurses and physicians being forced out of the Services?

ANSWER: The Air Force does not have a problem with mid-career active duty physicians being forced out of the Service due to lack of promotion opportunity. Promotion opportunities to major, lieutenant colonel, and colonel for physicians are the highest of any competitive category in the Air Force.

Promotion opportunity is a problem for active duty nurses in the Air Force. Their promotion opportunities to major, lieutenant colonel, and colonel are the lowest of any Air Force competitive category. We are currently doing an extensive review of requirements for field grade nurses. Changes in health care delivery practices and increased nursing requirements for hospitalized patients demand increased experience levels in all areas of clinical practice. As we validate increased field grade requirements, the promotion outlook for mid-career nurses will improve.

To reduce the number of nurses forced to separate due to promotion nonselection, we are pursuing a selective continuation program for the Air Force Nurse Corps. Such a program would permit Nurse Corps captains twice passed over for promotion to major to be continued on active duty until retirement eligibility. Nurse Corps selective continuation provides a way to keep experienced nurses in the work force when they would otherwise be forced to separate.

PHYSICIAN AND NURSE SEPARATIONS CAUSED BY PROMOTION PASSOVER

Question. While a critical shortage exists (particularly in the event of war), such a program will not necessarily address the problems of mid-career nurses and physicians leaving for a lack of promotion opportunities. What can be done to address the problem of mid-career nurses and physicians being forced out of the services?

Answer: The loss of physicians and nurses due to promotion passovers must be addressed separately since the Army Nurse Corps was not granted an exemption from the DOPMA field grade limitations like the Medical Corps. Within the Army Nurse Corps the following separations have occurred due to promotion passovers based upon information on the Officer Master File (OMF):

<u>FY</u>	<u># of Passover Losses</u>
83	13
84	46
85	24
86	24
87	73
88	70

The number of officers separated due to passovers was excessive in view of the predicted shortage of nurses. However, due to the limitations placed upon the officer corps at the field grade level by the Defense Officer Personnel Management Act (DOPMA) not all nurses considered for promotion could be selected. The majority of

these forced losses occurred at the level of Captain competing for Major. For example, from 1985 to 1988 15% of the Army Nurse Corps being considered for promotion to the grade of major were nonselected and subsequently separated from the service. This was recognized as a problem in view of the national shortage of registered nurses. Accordingly, during FY88 a policy of selectively continuing all fully qualified nurses in their current grade was instituted for those nurses who would have been forced to separate. The results of this policy will be realized in FY89 statistics. While it is recognized that not all of the nurses who are nonselected for promotion will elect to continue in the service, it was a policy change that is at least consistent with our current nurse corps shortage. The average selection opportunity for each of the field grades within the Army Nurse Corps has been close to the DOPMA desired goals over the past few years. The loss of nurses or any other category of officer is expected, given the limitations imposed by the DOPMA. The future projection for promotions in the Army Nurse Corps to the grade of major is expected to improve. Unfortunately, this improvement is a function of relatively small year groups approaching the consideration window. The improved opportunity and availability of selective continuation will reduce the magnitude of our losses due to promotion passover during the next several years. However, keeping the Army Nurse Corps under the constraints of the DOPMA field grade limitations insures that some nurses will be forced out due to promotion passover. The order of magnitude will be a function of the size of the year groups as they approach the consideration window. We recognize that there should be limitations placed on the size of the field grade force.

We believe that the current restrictions under the DOPMA are too great. The Army Staff is currently reviewing alternatives directed toward resolution of this restriction to include consideration of DOPMA relief. The loss of physicians due to promotion passovers is not as severe. The following separations occurred due to promotion passover in the Medical Corps for the years indicated:

<u>FY</u>	<u># of Passover Losses</u>
85	10
87	13
88	16

These numbers reflect those officers who are twice passed over for promotion. They do not totally reflect the number of losses that occur as a result of the promotion system since a number of physicians who are not selected the first time then elect to resign prior to being considered again for promotion. We are concerned with this aspect of our retention problem since this group is normally clinically proficient but lack military skills and knowledge that is assumed for all officers. By way of contrast with the Army Nurse Corps, for these same years, only 0.9% of those considered for promotion to Major in the Medical Corps were separated after being nonselected for promotion. Officers in the Medical Corps are exempt from the field grade officer strength limitations in the DOPMA which accounts for the relatively small number of physicians being forced to separate. I would not view this loss rate to be excessive as I did for the Army Nurse Corps. There is a fundamental personnel management principle that losses from any work force will occur due to failure to advance. The current rate in the medical corps is within acceptable limits and no action is required.

QUESTIONS SUBMITTED BY SENATOR INOUE FOR ADMIRAL ZIMBLE

Dr. Mayer's statement made reference to "Project Restore", an initiative to return more of the medical treatment for DoD beneficiaries to the direct care system. The belief is that these services can be provided on a more cost-effective basis through military hospitals and clinics, both for the government, and the patients.

QUESTION: Do you agree that bringing more of the workload back from CHAMPUS into military treatment facilities could produce a savings? Do you have an estimate of what each additional dollar apportioned to direct care could save in terms of CHAMPUS costs?

ANSWER: Yes, we can definitely produce a savings by using our existing military treatment facilities. For each dollar spent in the direct care system, we estimate we can save \$1.20 in CHAMPUS costs.

QUESTION: Absent funding constraints, how much additional funding could the direct care system absorb in fiscal year 1990, and what offset from CHAMPUS would you anticipate?

ANSWER: Beyond the funding already requested what we could most use is increased flexibility to spend the funds allocated for CHAMPUS.

To gain maximum benefit from health services contracting and to continue the gains we are making retaining and hiring civilian personnel, we have budgeted \$140 million for Health Care Contracting in FY 1990 and \$246.2 million in FY 1991. The ratio of CHAMPUS reduction (in dollars) to contract dollars is 1.2 to 1.

The FY 1990 Amended Budget includes an additional \$38 million in FY 90 and \$45 million in FY 1991 to continue efforts funded with the \$87.5 million FY 1989 Congressional add, and identified by the Navy Blue Ribbon Panel. Other initiatives, such as additional support provided the NAVCARE Clinics, are expected to generate savings which can be used to fund FY 1990 and FY 1991 costs. As you are well aware, many of our problems are not solved by additional funding. Recruiting and retention of qualified medical personnel is of highest priority. Strong management oversight is also necessary to generate the most benefits from the resources provided. We continue to monitor, evaluate, and adjust programs where necessary to support initiatives that increase in-house workload and improve the quality of medical care.

QUESTION: In what areas would you focus additional funding in the military medical system?

ANSWER: As indicated previously, many of our problems are not solved by additional funding. Recruiting and retention of qualified medical personnel is our highest priority. Strong management oversight will be needed for this effort. Limited additional military personnel funds could be used for Medical Corps and Nurse Corps accession bonuses, and retention including buy-out of insurance tails for physicians and authority for SECNAV to pay retention for nurses as contained in S.130.

The FY 1990 amended operation and maintenance, Navy budget request includes sufficient additional funds, \$38 million for FY

1990 and \$45 million for FY 1991, for additional clerks and non-medical manpower, for strengthened continuing medical education, and increased family practice support in Station Hospitals.

The quality of the medical program cannot be sacrificed to quantity. The OMN budget request reflects the maximum executable level which addresses this balance.

Although, we have shortfalls in funding for the replacement of medical equipment, we believe these shortfalls are manageable. We are procuring all essential equipment and are looking for equipment purchases with a good return on investment. In this regard, we are maximizing our use of the Productivity Enhancement Incentive Fund to reduce our replacement backlog.

QUESTION: In each of your commands, which facilities face the greatest needs?

ANSWER: Naval Hospitals Portsmouth, Oakland, Jacksonville, Long Beach, 29 Palms, and Naples have the greatest need for physicians, nurses, and support personnel. Portsmouth, Oakland, 29 Palms and Naples also need a replacement hospital. At the new Naval Hospital San Diego, parking has become a serious problem. Additional construction for parking is needed to help resolve this problem.

QUESTION: It is my understanding that a common complaint reported from military medical personnel is their frustration over the non-patient treatment duties they face. The time physicians, nurses, and other professionals spend outside their direct mission subtracts from the number of patients that can be treated, and their own job satisfaction. What efforts are underway to increase productivity of your healthcare providers in military treatment facilities?

ANSWER: With the \$15 million received from Congress for clinical and clerical support in FY-89, our commands have been given the authority to hire additional support staff--nurses, technicians, and clerks--in clinical and clerical areas. Additionally, part of the \$15 million has been used to retain civilian positions that were targeted for release as part of the military substitution program. The Navy Blue Ribbon Panel reviewed the military substitution program and determined that 416 civilian positions are needed because some required skills cannot be substituted effectively with non-medical enlisted personnel.

Approximately 160 clerks are being hired to support physicians; the initial emphasis is on the four teaching hospitals. It is projected that these employees will be brought onboard during April and May 1989.

At Naval Hospital Newport, 18 civilian registered nurses are being hired to support the family practice physicians and the "Family Practice Hospital" concept being implemented there.

To further assist physicians in their capability to see more patients, the Navy is expanding the physicians' assistants program. A dual course is being pursued--direct accession and in-service procurement--as well as hiring civilian physicians' assistants. We have enhanced the Navy physicians' assistants program by establishing an opportunity for commissioning in the

Medical Service Corps beginning in FY-89. Offering a commissioning option will enable the Navy to be competitive with the other Services. At present military physicians' assistants are warrant officers.

The Navy PA community will increase to 300 by FY-91 and the in-house training program will begin in September 1989. Training will be held at Naval School of Health Sciences, San Diego, California, and will train between 20 and 25 physicians' assistants per year. Commissioning in the Medical Service Corps will take place upon graduation.

Funding has been requested in the FY-90 budget to build the civilian physicians' assistants program. The President's budget requests funding for 140 civilian physicians' assistants in FY-90.

QUESTION: What are your current shortfalls in administrative and support personnel in military medical facilities.

ANSWER: We currently have a shortfall of 808 clerical support personnel and 544 unfilled Nurse Corps billets. Within the nurse shortfall is an acute shortage of critical care nurses and nurse anesthetists. Our present inventory is just 53 percent of our requirements. These most critical civilian personnel needs are being addressed with the \$87.5 million added by Congress for FY 1989. We are now hiring and contracting for additional nurses, technicians, and clerks in clinical and clerical areas. These additional civilians will be hired over the next three years, which is as quickly as they can be recruited. The Nurse Corps shortage is an out-growth of the shortage of nurses nationwide. The Navy is applying extra recruiting effort to alleviate the shortage, and the DoD budget contains legislative initiatives to enhance programs designed to attract and retain nurses.

SENATOR INOUE: Are there any initiatives underway to address the problem of physicians and nurses losing time from their primary duties to perform administrative functions?

ADMIRAL ZIMBLE: Additional support personnel are being hired to provide physicians with administrative help; ward clerks are being hired to provide support to nurses. — Approximately 416 personnel will be hired or retained in FY-89 to provide clinical and clerical support for physicians and nurses. An additional 160 clerks will be hired to support physicians. Initially the emphasis will be on the teaching hospitals. As this effort results in increasing productivity, additional clerical support personnel will be hired in FY-90.

ROLE OF DOD CIVILIAN AND CONTRACT NURSES

QUESTION: To meet minimum staffing requirements, civilian and contract nurses have been brought into DoD medical facilities, to work along side the professional military staff. In the Navy, such employees constitute almost 20% of the total full-time nursing staff.

What is the cost effectiveness of hiring civilian or contract nurses versus a full military staff?

ANSWER: Once minimum military nurse staffing is achieved to support active wartime nursing requirements, civilian (civil service) personnel are the more cost-effective form of manpower. However, since there is a nationwide shortage of nurses, in some high-cost areas federal salaries are not competitive. Special pays help to recruit civilian nurses in areas like San Diego and Bethesda. Based on current cost estimates, contractor nurses exceed the cost of civil service nurses.

QUESTION: Can you meet your short-term staffing goals with contractor and civilian personnel?

ANSWER: In many instances, contract nurses are meeting the short term staffing goals. Civilian nurses comprise about 20% of nurses in MTFs (excluding contractors), and have augmented the military nurses for years. It is difficult to hire civilian nurses in high cost areas, and, therefore, civilian nurses could not fill the gap in all instances.

QUESTION: What impact does reliance on contract and civilian nurses have on the military nursing staff at DoD hospitals?

ANSWER: Having a mix of military, civilian, and contractor personnel, each with varying salaries and hours of work, has created some morale problems among military and civilian nurses. However, overall, the MTFs could not continue to function without the addition of these personnel.

QUESTION: What is the maximum percentage of non-military nurses in DoD hospitals and clinics that you would consider acceptable?

ANSWER: My personal preference would be to staff our hospitals 100% with active duty Navy nurses. Budget realities obviously preclude that from happening. At a minimum we seek to have in the active force those personnel required to support our active component wartime requirement. These personnel are then distributed to our military treatment facilities in accordance with established staffing priorities. I would prefer staffing the balance of our medical care requirements with civil service nurses. I would retain the contract alternatives to support a facility's short-term workload peaks. However, there is no optimum mix of active duty, civilian hire, and contract nursing personnel pre-established for our activities.

QUESTIONS SUBMITTED BY SENATOR BYRD FOR ADMIRAL ZIMBLE

QUESTION: The Commission on Base Realignment and Closure submitted its list of bases to Congress. Included in this list of proposed closings are medical facilities (that are a part of the bases listed) that provide health care to individuals who have retired near these bases and become dependent upon these services. What actions does the Department of Defense intend to take to continue providing these health care services to these retirees?

ANSWER: Plans for the provision of care for retirees who live in the area of the medical facilities affected by the proposed list of base closures have been underway for several months. The closure of the Naval Hospital, Philadelphia and changes at Walston Army Hospital at Fort Dix will affect those medical facilities in the Delaware Valley which are supported by these hospitals.

Commander, Naval Medical Command (COMNAVMEDCOM) has recommended building a comprehensive outpatient clinic at the Philadelphia Naval Shipyard and modifications are being planned to the Veterans Administration Hospital to provide inpatient care for military beneficiaries. Current plans call for construction of a shipyard clinic in FY-91 with contingency plans for expansion, if necessary, in later years. Discussions continue between Navy and OASD(HA) concerning the scope of services offered at the proposed clinic should be, whether healthcare should be limited to active duty, and the role of the VA in providing medical care to Navy beneficiaries in Philadelphia. In the event that the planned clinic will not provide care for beneficiaries, it will be necessary to rely on the CHAMPUS system.

The closure of Naval Station, New York (Brooklyn), would include closure of our medical clinic by FY-94. COMNAVMEDCOM has recommended the construction of a medical/dental clinic on Staten Island to absorb the workload of the Brooklyn clinic and the additional workload associated with homeporting a battleship battlegroup. The Uniformed Services Treatment Facility (USTF) on Staten Island, Bayley Seton Hospital, would provide inpatient care and outpatient services to complement the primary care provided by the proposed clinic for active duty personnel and the vast majority of care for other beneficiaries. The USTF is an example of an alternative to CHAMPUS which is affordable for the beneficiaries.

The Delaware Valley Health Services System (DVHSS) was established in May 1988 to plan for efficient and effective coordination of Federal health care resources in an area from New Jersey to 40 miles south of Philadelphia, including NAVHOSP Philadelphia and Walston Army Hospital. The DVHSS is currently addressing this issue.

The San Francisco Bay area is another location in which the recommendations of the Commission will adversely impact our ability to meet the need for health care. The recommended closure of Letterman Army Medical Center (LAMC) will hamper our Graduate Medical Education (GME) program at NAVHOSP Oakland. Alternatives to CHAMPUS for those now using LAMC must be approved under the CHAMPUS Reform Initiative, which is an OASD(HA) program operating in California. An economic analysis

to determine optimum policies for military health care in the Bay Area has been sponsored by OASD(HA).

Other closures recommended by the Commission include Pease AFB in New Hampshire and Chanute AFB in Illinois. About 80% of the workload in our nearby Portsmouth, New Hampshire clinic is associated with occupational health and industrial hygiene; it is not a comprehensive healthcare clinic.

QUESTION: Are whatever substitute health care services contemplated by the Services comparable in terms of price and quality of care?

ANSWER: The substitute health care services described in question #43 will be comparable in terms of quality of care. Other recommended closures are projected to increase our CHAMPUS costs, and we see no other alternative. Depending on the area in which the retiree lives, the lack of military medical care may increase the out-of-pocket expense for the retiree.

SENATOR BYRD: While a critical shortage exists (particularly in the event of a war), such a program will not necessarily address the problems of mid-career nurses and physicians leaving for a lack of promotion opportunities. What can be done to address the problem of mid-career nurses and physicians being forced out of the services?

ADMIRAL ZIMBLE: The loss of mid-career nurses and physicians is indeed a serious problem. When we lose a mid-career professional, we lose not only a skilled provider - we lose a valuable leadership and teaching resource. We lose the investment made over years of training and progressively more responsible assignments.

For nurses, immediate ameliorative steps would be to remove the officer grade strength controls from the Nurse Corps and to provide retention bonus authority like that included in S. 130. The DOPMA control grades are especially damaging because they prevent us from promoting otherwise eminently qualified officers. This particular problem is beginning to also affect the line Navy. The line recently gave up 300 promotion slots to the Nurse Corps to enable them to facilitate Nurse Corps promotions into actual grades.

For physicians and nurses, we are pursuing compensation packages that will make us more competitive with the private sector and other government agencies.

QUESTIONS SUBMITTED BY SENATOR INOUE FOR GENERAL MILLER

. CHAMPUS AND DIRECT HEALTH CARE COSTS

QUESTION: Do you agree that brining more of the workload back from CHAMPUS into military treatment facilities could produce a savings?

ANSWER: Yes, and we are actively pursuing such opportunities through partnership agreements and initiatives made possible by the alternate use of CHAMPUS funds. We are in the early stages of these "restore" efforts, but I view their potential for related CHAMPUS savings as significant. Further, these efforts improve access to high quality, affordable health care for our people.

QUESTION: Do you have an estimate of what each additional dollar apportioned to direct care could save in terms of CHAMPUS costs?

ANSWER: Savings to CHAMPUS under partnership agreements are realized more from the change in delivery site than from investment in the direct care military treatment facility (MTF). Under these agreements civilian providers can treat CHAMPUS patients in the MTF and submit their claim for service to CHAMPUS for payment. The savings here occur to the extent the fixed assets and support services of the MTF; e.g., x-ray, lab, pharmacy, are used as opposed to civilian sources. The Services, in coordination with DOD, are developing a mechanism for tracking savings associated with these agreements.

The projects designed for the alternate use of CHAMPUS funds are structured to produce net verifiable CHAMPUS savings. We have a number of these projects in various stages of contracting with services to begin later in the fiscal year. While it is premature to determine related savings at this time, I feel confident that CHAMPUS savings will be achievable.

QUESTION: Absent funding restraints, how much additional funding could the direct system absorb in fiscal year 1990, and what offset from CHAMPUS would you anticipate?

ANSWER: The President's Budget (PB) submitted to Congress adequately funds the O&M budget in support of the Air Force Direct Care System for FY 1990. The PB contains O&M funding for Managed Care Initiatives and incorporates the corresponding offset in the CHAMPUS requirement. The CHAMPUS "Flex" authority provides sufficient flexibility to fund any additional Management Initiatives that may be submitted in the near future. Potential offsets from future initiatives cannot be accurately projected at this time.

QUESTION: In what areas would you focus additional funding in the military system?

ANSWER: The FY 1990 O&M President's Budget adequately funds the essential Direct Care and CHAMPUS program requirements. However, the adequacy of the provider to support staff ratio has been questioned recently as evidenced by a current GAO study entitled "DOD Health Care - Extent to Which Military Physicians Perform Administrative Tasks", GAO/HRD 89-53, dated February 1989. While the ideal ratio has yet to be determined, it is generally agreed there is not sufficient support staff to accommodate the needs of our providers. Left unchecked, this condition could negatively impact the morale, productivity and retention of military providers. Furthermore, when we conduct our manpower reapplication exercise each year, we find that, based on existing manpower standards, we have a requirement for approximately 4,000 more people than currently authorized, of which an estimated 2,900 are for support personnel (1,900 medical support personnel and 1,000 administrative support personnel). Therefore, if we received unspecified additional funding, we would place a high priority on funding additional personnel authorizations.

QUESTION: In each of your commands, which facilities face the greatest needs?

ANSWER: The more critical needs vary from one facility to the next, ranging for the most part from facility constraints to specialty and support staff personnel shortages. Facilities in sun-belt areas with a heavy concentration of retirees generally have a demand for care greater than their capability and the highest CHAMPUS costs.

PRODUCTIVITY FOR HEALTHCARE PROVISIONS

QUESTION: It is my understanding that a common complaint reported from military medical personnel is their frustration over the non-patient treatment duties they face. The time physicians, nurses and other professionals spend outside their direct mission subtracts from the number of patients that can be treated, and their own job satisfaction.

What efforts are underway to increase the productivity of your health care providers in military treatment facilities?

ANSWER: Current initiatives to increase the amount of direct patient care time for our providers are:

A Retention Working Group to provide recommendations to the AF Surgeon General on how to resolve issues related to inadequate administrative and ancillary support. The basic need is more administrative, clerical and technician personnel.

Development of plans for several test sites to evaluate, by specialty, variable support to provider ratios, examination room to provider ratios, facility design and then to compare them to civilian standards.

The implementation of several automated system enhancements to decrease administrative and patient demands on physicians, such as application software for the Coronary Artery Risk Evaluation (CARE) System, Automated Quality of Care Evaluation Support System (AQCESS), Standard Appointing and Scheduling System (SASS), Automated Physical Examination System, Appointment Reminder System for Outpatients, and the Automated Central Tumor Registry (ACTUR) System.

Revision of the Quality Assurance program to decrease paperwork and administrative requirements on the providers.

Testing of organizational changes; e.g., Director of Ambulatory Services (DAS) to improve utilization of resources.

Establishing process review techniques to eliminate waste, rework and redundancy in the medical treatment facilities.

Procurement and implementation of 25 programs/projects which provide for efficient and cost-effective operations. Funding for these was specifically provided in the FY 1989 Appropriations Act for improvement of management efficiency.

Implementation of nine projects using CHAMPUS funds flexibility approved in the FY 1989 Appropriations Conference Report.

QUESTION: What are your current shortfalls in administrative and support personnel in military facilities?

ANSWER: Based on the annual reapplication of the manpower standards we have approximately 4,000 unfunded manpower requirements. Of these 1,900 are unfunded medical support authorizations and 1,000 are unfunded clerical support authorizations. These unfunded authorizations are based upon engineered manpower standards determined primarily by past workload; they do not reflect any projected increase in retiree care or recapture of the expensive CHAMPUS outlay.

QUESTION: Are there any initiatives underway to address the problem of physicians and nurses losing time from their primary duties to perform administration functions?

ANSWER: Our current initiatives, as previously stated, are intended to increase the amount of direct patient care time for our providers.

QUESTIONS SUBMITTED BY SENATOR INOUE FOR GENERAL ADAMS-ENDER

ROLE OF DOD CIVILIAN AND CONTRACT NURSES

QUESTION. To meet the minimum staffing requirements, civilian and contract nurses have been brought into DoD medical facilities, to work along side the professional military staff. In the Navy, such employees constitute almost 20% of the total full-time nursing staff. What is the cost effectiveness of hiring civilians or contract nurses versus a full military staff?

ANSWER. The Army Nurse Corps uses Civil Service registered nurses and contract nurses. Civil Service nurses are staff nurses, head nurses and supervisors, and represent 37% of the Army's professional nurse staff. Contract nurses are utilized solely as staff nurses and represent 251.18 work years. Cost comparison for the military, Civil Service and contract nurses is as follows:

	<u>*Military(2/LT)</u>	<u>**Contract</u>	<u>**Civil Service(GS-9/5)</u>
Staff Nurse	\$34,023	\$51,063	\$27,027

*Cost includes salary and benefits.

**Cost includes average salary only. Walter Reed Army Medical Center costs are \$89,000 for ICU nurse, \$79,000 for medical-surgical nurse.

In addition to the cost ineffectiveness of contract nurses, the availability of this option is unreliable and unpredictable. For example, at Walter Reed Army Medical Center to fill one work year, 2-3 different nurses are utilized, which present continuity of care concerns and orientation liabilities. Further, the show rate or fill rate on any given day is only 70%. In light of the nationwide shortage of nurses, contracts enacted today can be ineffective tomorrow because of the civilian sector's ability to increase incentives instantaneously.

Further increases in the Civil Service registered nurse force is unacceptable because of the current shortage in the Federal sector and the nation, and the mobilization threat, e.g., already insufficient active component authorizations to meet mobilization needs.

QUESTION. Can you meet your short-term staffing goals with contractor and civilian personnel?

ANSWER. Short-term staffing goals cannot be met with contract and civilian personnel. The nationwide shortage of registered professional nurses is the major reason for this opinion. Assuming that additional incentives would be made available to increase competitiveness with the civilian sector, the situation would improve, but not be solved. Contract nurses are bedside staff nurses who are responsible for nursing care to a determined number of patients. They cannot fill a leadership role and as such, simply augment the nursing care team. The lack of incentives for Civil Service registered nurses plus the dilution of the mobilization preparation force, precludes this option as a solution.

QUESTION. What impact does reliance on contract and civilian nurses have on the military nursing staff at DoD hospitals?

ANSWER. Reliance on contract and civilian nurses has had an impact on the military nursing staff in Army hospitals. Scheduling preference for civilians (contract and civil service) is necessary to attract and retain. This leaves the undesirable shifts to be manned by the military. Although overtime pay is often offered to Civil Service employees, it requires compliance. Therefore, military nurses must work longer hours (50 hours estimated per week) with fewer days off and no additional compensation. It is conceivable to have three different nurses (military, civil service, contract) with similar qualifications taking care of the same patient, but receiving vastly different pay, working different total hours and having different degrees of accountability and responsibility. There are examples of Civil Service nurses exiting to take more lucrative positions with contract agencies and military nurses exiting to take more lucrative opportunities in the civilian sector.

QUESTION. What is the maximum percentage of non-military nurses in DoD hospitals and clinics that you would consider acceptable?

ANSWER. The estimated peacetime nurse requirement using the Joint Healthcare Manpower Standards are 8,007. The military portion to support COMPO 1 readiness (100% TOE fill plus 25% MOB TDA Fill) is 5,617. Therefore, the maximum percentage of non-military nurses which would be considered acceptable is 29.8%.

Current Civil Service nurse authorizations plus military end strength equals 7,299, which is 708 short of the estimated requirements. The Civil Service nurse portion currently is 37% (2,721 authorizations) and the military end strength is 63% (4,578).

PROFESSIONAL NURSING

QUESTION. General Adams-Ender (Army), it has recently come to my attention that there currently is no military school of nursing. We do have, in Bethesda, military schools for medicine and even psychology, but not for nursing.

I understand that the three chief nurses have been discussing various possibilities and, further, that you recently visited the Tripler Army Medical Center in Hawaii to explore whether that might be an appropriate site for such a program. I have been assured by both the University of Hawaii School of Nursing and its President that they would be most supportive of such an endeavor. Would you please provide us with your current thoughts on this possibility?

ANSWER. The issue of a military school of nursing was first raised in September 1987 by the Dean of the Uniformed Services University of the Health Sciences (USUHS) during a Strategic Planning Conference. The possibility was further discussed with me and the Chief Nurses of the Uniformed Services. We all agreed in concept that a school of nursing was

a viable option to ensure steady input of nurse accessions into the services. During September 1988, a task force group was formed to explore the relevant issues and to make recommendations to the Surgeon Generals in May 1989. The Surgeons General all agree that a school of nursing within the USUHS would be a definite asset.

In February 1989 during a visit to Tripler Army Medical Center, I met with nursing leaders in education, Federal and State government services in Hawaii. They were most cooperative and we concluded that Hawaii would be an ideal site for the school of nursing. Hawaii provides the greatest opportunities for joint agency health care experiences for the nurses along with a highly supportive academic environment in the civilian sector. There would be a need to ensure adequate family housing for the nursing students since the majority of them would be married and have young children.

After the report to the Surgeons General, the plan is to continue to support the legislative actions necessary to make a school for the Federal Services a reality.

QUESTIONS SUBMITTED BY SENATOR INOUE FOR GENERAL GOODWIN

ROLE OF DOD CIVILIAN AND CONTRACT NURSES

To meet minimum staffing requirements, civilian and contract nurses have been brought into DOD medical facilities, to work along side the professional military staff. In the Navy, such employees constitute almost 20% of the total full-time nursing staff.

QUESTION: What is the cost effectiveness of hiring civilian or contract nurses versus a full military staff?

ANSWER: Of the three alternatives for staffing our nursing requirements, the least expensive is the civil service employee, approximately \$13 to \$15 per hour for a GS-9. Civilian nurses, however, are not readily available in the civilian sector or will not agree to civil service employment at the current grade due to the non-competitive salary. Contract nurse costs, as evidenced by existing contracts at Brook Army Medical Center (BAMC) and Wilford Hall Medical Center (WHMC), range between a low of \$20 per hour for a general duty nurse on a day shift to a high of \$27 per hour for a contract nurse staffing an intensive care unit. As with civil service nurse recruitment, the contractor has not been able to attract civilian nurses against all established requirements, particularly the less desirable shifts and the positions at the lower salary range. To the extent the medical center fills its less desirable schedules with active duty nurses while the contract nurses assume the more interesting and higher salaried positions, the medical center could severely impact the morale of its military nursing staff. Conversely, the Air Force can staff its nursing requirements with military nurses at an hourly rate of

approximately \$24 to \$26. This computation assumes the pay grade of a Captain (O-3) and includes such factors as basic pay, retirement pay annuity, PCS costs, housing and subsistence allowances. An analysis of the alternative sources for obtaining nursing support based solely on cost effectiveness assumes other factors are equal. However, management flexibility, the equitable assignment of nurses to various shifts in a 24 hour period, and the staffing of wartime nursing requirements is greatest with a full military nurse staff complement. The combination of costs, management flexibility, and readiness requirements suggests a full military nurse staff structure best accommodates our nursing requirements.

QUESTION: Can you meet your short-term staffing goals with contractor and civilian personnel?

ANSWER: In general, short-term staffing requirements demand flexibility and timeliness that are expensive and that contractor or civilian personnel find difficult to meet. Our civilian positions usually do not have competitive salaries or benefits; e.g., career progression, flexible scheduling, to offer well-qualified nurses who increasingly are highly sought in the civilian sector.

Relying on contracts is not the answer either. Putting a contract together, advertising it, and making the award take considerable time. The process is complicated by contractors that are not able to fulfill conditions of the contract.

Civilians, whether government hires or contracted, cannot meet mobility requirements during times of conflict. The civilians' presence can also have a negative impact on the morale of our military nurses when the disparity in compensation and working conditions becomes too large.

QUESTION: What impact does reliance on contract and civilian nurses have on the military nursing staff at DOD hospitals?

ANSWER: Relying on contract and civilian nurses at DOD hospitals often increases the burden on military nurses to pull "overtime" and the less desirable work shifts, and decreases the capability to respond during readiness exercises. As part of the shrinking pool of nurses, civilian and contract nurses are free to go where the salaries and benefits are the best and, not surprisingly, do so. When the disparity in compensation and working conditions between the military and civilian "team" members becomes too great, the morale of military nurses is hurt.

QUESTION: What is the maximum percentage of non-military nurses in DOD hospitals and clinics that you would consider acceptable?

ANSWER: As a point of departure it should be noted that the Air Force, not unlike the other Services, has a significant wartime shortfall of military nurses -- nearly 16,000 Active and Reserve nurses are required whereas the available supply, including Reserve Component resources, is slightly

less than 10,000. The majority of these requirements is founded in the need to staff 21,000 hospital beds in the theaters of operation and to establish a worldwide aeromedical evacuation system. Both of these priority missions demand rapid mobility and deployment from our CONUS-based peacetime force structure and by their very nature must be satisfied with military versus DOD civilian or contract nurses. Accordingly, the number or percentage of non-military nurses has historically been quite low in the Air Force (at present approximately 12%). Any amendment to this posture that would favor a greater percentage of civilian nurses would be inadvisable and would only serve to exacerbate our shortfall of military nurses that we need to meet our contingency responsibilities.

SUBCOMMITTEE RECESS

Senator INOUE. The subcommittee will now stand in recess until tomorrow at 2 p.m., when we will hear from the Chairman of the Joint Chiefs of Staff, who will present a global overview of defense issues. The subcommittee will stand in recess.

[Whereupon, at 12:15 p.m. Thursday, March 16, the subcommittee was recessed to reconvene at the call of the Chair.]



DEPARTMENT OF DEFENSE APPROPRIATIONS FOR FISCAL YEAR 1990

TUESDAY, JUNE 20, 1989

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, DC.

The subcommittee met at 3:38 p.m. in room SD-192, Dirksen Senate Office Building, Hon. Daniel K. Inouye (chairman) presiding.

Present: Senator Inouye.

DEPARTMENT OF DEFENSE

ARMY MEDICAL ISSUES

STATEMENT OF MAJ. GEN. GIRARD SEITTER III, COMMANDING GENERAL,
TRIPLER ARMY MEDICAL CENTER, U.S. ARMY HEALTH SERVICES
COMMAND, DEPARTMENT OF THE ARMY

OPENING STATEMENT OF SENATOR INOUE

Senator INOUE. It gives me particular pleasure to welcome Maj. Gen. Girard Seitter, Commanding General of Tripler Army Medical Center in Honolulu. General Seitter has had a distinguished career in medicine, especially in military medicine. The list of his assignments and responsibilities are too numerous to mention here, and so I shall not attempt to do so. Suffice it to say that there is perhaps no one more qualified than he to address both the strengths and the weaknesses of medical care in the Army.

Obviously we in Hawaii are extremely proud of Tripler, the only military hospital in our State. Tripler has one of the largest workloads of any Army medical center. Being the only Federal referral hospital in the Pacific region, it serves not only Hawaii but also the trust territories, Guam, the Philippines, Korea, and Japan.

Tripler is affiliated with the University of Hawaii Medical School as well as other medical schools in the continental United States. In addition, Tripler is an integral part of the CHAMPUS reform initiative. It plays a critical role in medical readiness throughout the Pacific.

All of us on this subcommittee are concerned that the medical care given active duty military, their dependents and military retirees shall be the best available. We are also concerned that this care should be available to all who are eligible.

During the course of this hearing we will have an opportunity to ask the General his views on what is right about health care and

medical treatment facilities and what can be improved and receive, I hope, his suggestions for improvement.

After General Seitter, we will hear from Col. John Leddy, the Chief of Army Optometry, on the role of optometry in the context of military medicine.

Again, General, welcome, sir. Please proceed as you wish. Your prepared statement has been made part of the record, and you may proceed in any way you wish.

General SEITTER. Thank you, sir.

ROLE OF MILITARY MEDICINE AND MEDICAL CENTERS

Mr. Chairman, members of the Committee, I am Maj. Gen. Girard Seitter III, commander of Tripler Army Medical Center, Honolulu, Hawaii. It is an honor to appear before this subcommittee to discuss the role of military medicine and medical centers in the military health care system and to present some of the challenges facing the Army Medical Department as well as some of our initiatives.

Medical centers are the heart of the Army medical health care delivery system. Centers of learning and knowledge, they provide new ideas and train people upon which the remainder of the system depends for sustainment and growth. For example, Tripler Army Medical Center provides patient care on a quad-service basis—Army, Air Force, Navy and Marines—as well as our retirees and veterans, to 285,000 beneficiaries in the local Hawaii area, and to an additional 346,000 by referral throughout the Pacific.

We have 121 residents training in 9 specialties and 4 fellows in specialty training. We have 83 people, many nationally recognized, working on 195 clinical research protocols.

Army medical centers have great impact upon the recruitment and retaining of health care professionals. Although recruitment of physicians remains difficult—and, I might add, probably always will—the probability and the possibility of staff assignments to a major teaching hospital is one of our greatest inducements.

Our strong graduate medical education program is the keystone of our recruitment effort for the scholarships which provide approximately 75 percent of all medical corps accessions.

TWOFOLD ROLE OF GRADUATE MEDICAL EDUCATION

Based in Army medical centers, the role of graduate medical education is twofold—to enhance patient care and to develop trained specialists. It also affects the young physician's positive attitude toward and understanding of military medicine. This in turn directly influences the number and quality of specialists available for field assignments throughout the world, as well as those oriented toward careers in military medicine.

I can clearly illustrate our medical center's contribution to postgraduate training and education. Of the Army's postgraduate medical trainees, 86 percent are in our 8 medical centers. Of 92 residency programs in 22 medical specialties, all but 5 are based in medical centers.

In addition, each medical center is located near a civilian university. Academic affiliations are essential to the advancement of med-

ical knowledge and quality care, and these mutually beneficial affiliations are a critical requirement of all accrediting bodies.

The Army medical center, with its diverse functions and capabilities, is also a powerful inducement to physician retention. The opportunity to work in a hospital with the highest reputation, to face the most difficult clinical challenges, and to participate in daily teaching attracts the very best of our physicians to the medical center.

These are the physicians who treat not only our most ill patients but who also advance the art of medicine and that discipline through research. Former Army physicians have even returned to active duty for the opportunity to serve in our medical centers.

ARMY MEDICAL DEPARTMENT

Sir, I now shift my thoughts from medical centers to the Army Medical Department in general and comment upon some of our challenges and concerns. Peacetime goals and initiatives focus on improving access to quality care, recapturing CHAMPUS workload, establishing innovative management practices, and recruiting and retaining the highest quality health care staff.

Programs have been initiated to increase services and staff at Army hospitals, and by carefully monitoring these programs and aggressively pursuing the resources they provide, most of our hospitals have successfully improved access to care.

TRIPLER MAJOR CONSTRUCTION AND RENOVATION PROJECT

An important aspect of access is the physical facility and, Mr. Chairman, I am very happy to report to you that as a result of your support a major construction and renovation project at Tripler is near completion. We are proud to serve our patients in one of the very finest medical facilities in the world, and we thank you very much.

We carefully control the movement of workload from our hospitals to CHAMPUS and take every opportunity to share health resources and capabilities within the Veterans Administration. Tripler's relationship with the VA began in 1931 and continues to be a cooperative and mutually-supportive arrangement.

RECRUITMENT AND RETENTION OF HEALTH PROFESSIONALS

Still, the most pressing issue in Army medicine today is the recruitment and retention of physicians, registered nurses and other medical specialists. I make just one comment directed at physician pay compensation, clearly a multifaceted issue, but I would make just one comment. And that is to say it is essential that primary care specialists—primary care specialists—be included in the proposed 1990 medical special pay plan.

In spite of productivity improvements, we are not able to use our medical facilities to their full capacity, primarily because of decreased staffing and nursing shortages. The Army Medical Department, sir, is committed to providing quality care to all beneficiaries. Army medical centers stand at the very heart of our health

care system; they make significant contributions to the recruitment and retention of health care professionals.

Their affiliation with our Nation's universities and medical schools advance the art of medicine for all. The Army Medical Department and Tripler Army Medical Center face many challenges in improving access to the peacetime health care delivery system, reducing the costs of CHAMPUS programs, and recruiting and retaining a quality work force.

I can tell you we are dedicated to meeting these challenges and have many initiatives in place or proposed in each area. With your continued support, Mr. Chairman, and assistance we will succeed in those endeavors.

Mr. Chairman, this concludes my prepared statement. I have submitted a more detailed report for the record, and I will be very happy to answer any of your questions.

[The statement follows:]

STATEMENT OF MAJ. GEN. GIRARD SEITTER III

Mr. Chairman and members of the committee, I am Major General Girard Seitter III, Commander of Tripler Army Medical Center, Honolulu, Hawaii. It is an honor to appear before this subcommittee to discuss the role of medical centers in the military health care delivery system, and to present some challenges facing the Army Medical Department (AMEDD), as well as some of our initiatives.

THE MEDICAL CENTER

Medical centers are the heart of the Army health care delivery system. Centers of learning and knowledge, they provide new ideas and trained people upon which the remainder of the system depends for sustainment and growth. Medical centers have one mission—to provide medical care for our soldiers and their families. This mission has four equally important components: acute and tertiary (referral) patient care for all beneficiaries, graduate medical education, clinical research, and medical readiness.

Tripler Army Medical Center provides patient care on a quad service basis to approximately 258,000 beneficiaries in the local Hawaii area, and to an additional 346,000 by referral throughout the Pacific. We have 121 residents training in nine specialties, and four fellows receiving subspecialty training. We have 83 people, many of whom are nationally recognized, working on 195 clinical research protocols.

IMPACT OF MEDICAL CENTERS ON RECRUITMENT

Recruitment of fully trained medical specialists is difficult, despite expectations that changing conditions in civilian practice might encourage large numbers of physicians to enter the military. The strength and availability of our medical center-based Graduate Medical Education (GME) programs, and the opportunity to serve at some time in a major teaching hospital, however, are the most significant factors in recruiting medical students for Army scholarship programs. These programs provide approximately 75 percent of all new Army physician accessions. Our medical centers are clearly the keystone of Graduate Medical Education, and GME impacts heavily upon recruitment.

ROLE OF GME IN MILITARY MEDICINE

GME programs in Army hospitals have two major functions: to enhance the quality and quantity of patient care, and to develop trained specialists. Further, our GME programs affect the young physician's attitude toward, and understanding of, military medicine. The size and quality of GME programs, therefore, directly influence the number and quality of specialists available for field assignments, as well as the number of specialists oriented toward careers in military medicine.

GME programs have another major effect upon the Army's recruitment and retention efforts. The larger the GME program, the more Health Professional Scholarship Program (HPSP) graduates can benefit from GME in Army hospitals. Since these physicians are on active duty during the years they spend in residency training, and only later begin to serve their obligated service terms, the size of our GME

programs makes it possible to bring more HPSP students on duty and to keep them longer. The size and quality of GME programs also affects the number of physicians who remain on active duty because of their interest in teaching assignments. Finally, it is probable that a larger portion of physicians who receive their GME training in Army hospitals elect to remain on active duty after completion of their obligated service than do those who commence obligated service after completing GME in civilian hospitals.

IMPACT OF MEDICAL CENTERS ON TRAINING

At our medical center, the most severe and complex diseases and injuries are matched against the most sophisticated diagnostic and treatment capabilities provided by a full range of specialists and subspecialists. The resulting mixture of very ill patients, well-trained physicians, and state-of-the-art technology provide the necessary environment for health professional education and clinical research. In addition, each medical center is located in proximity to civilian universities. Academic affiliations are essential to the continued advancement of medical knowledge, and the provision of the highest level of patient care. These mutually beneficial affiliations are a critical requirement of all accrediting bodies.

Our medical centers' contribution to postgraduate training and education is clear. Of 92 Army residency programs in 22 medical specialties, all but five are in medical centers. Of 71 fellowship programs in 39 disciplines, all are in medical centers. Overall, 86 percent of the Army's 1,703 subsidized postgraduate medical trainees are in our eight medical centers.

IMPACT OF MEDICAL CENTERS ON RETENTION

I do not suggest that medical centers alone possess our best physicians. There are excellent doctors in Army facilities around the world, primarily in smaller hospitals. Without the possibility of advanced training or staff assignments to a medical center, however, these young physicians would face a limited future. The opportunity to work in a hospital with the highest reputation, to face the most difficult clinical challenges, and to participate in daily teaching attracts the very best of our doctors to our medical centers. These are the physicians who treat not only our most ill patients, but who also advance the art of medicine through their research. They are rewarded by a stimulating academic environment, early assumption of major responsibility, and a close and equal relationship with their civilian counterparts. Former Army physicians have even returned to active duty for the opportunity to serve in our medical centers. The Army medical center with its diverse functions and capabilities is a powerful inducement to Army physician retention.

ARMY PEACETIME HEALTH CARE GOALS AND INITIATIVES

The Army peacetime health care system consists of direct patient care and the Civilian Health and Medical Program of the Uniformed Service (CHAMPUS). When direct care capability is exceeded or unavailable, beneficiaries, other than active duty, are provided statements of nonavailability to use CHAMPUS. The Army's peacetime goals and initiatives focus on improving access to quality care; recapturing CHAMPUS workload; establishing innovative management practices to manage both CHAMPUS and direct care funds; and, recruiting and retaining the highest quality health care staff.

IMPROVING ACCESS TO QUALITY CARE

A major goal of the Army health care delivery system is to improve access to care. Many programs have been initiated to increase services and staff at Army hospitals. The Primary Care to Uniformed Services (PRIMUS) program, the Family Practice Model, and partnership agreements funded by CHAMPUS, have been successfully implemented. The Army Medical Enhancement Program (AMEP), a program strongly supported by Congress, is the cornerstone of our plan for achieving a 95 percent level of required staffing at medical facilities. The AMEP creates a primary care model for all Army families, improves the patient appointment system, and helps obtain additional ancillary support personnel.

Tripler Army Medical Center has been successful in improving access to care for its many beneficiaries by carefully monitoring all programs designed to assist this effort, and by aggressively pursuing resources provided by those programs. We recently made the following improvements:

- Use of the Army Medical Enhancement Program (AMEP). The AMEP is used at Tripler to expand the quantity and quality of care provided in our emer-

gency room, enhance operating room and anesthesia nursing (active operating room suites have been expanded from 8 to 12), increase ambulatory surgery services, initiate open-heart surgery, and improve and expand our intensive care units. Ancillary services have been increased to support additional workload, and twelve additional appointment clerks were recently hired. The phones in our central appointments system are now answered on the first or second ring.

- Primary care Partnerships with civilian practitioners. Partnership agreements are in place to provide services in pediatric surgery, the adult outpatient clinic, orthopedics, and vascular surgery. Additional partnerships have been approved, and will begin shortly, in nurse anesthesia, family practice, outpatient psychiatry, cardiology, and after-hours pediatrics.
- “Adopt-A-Doc” Program. This program encourages military hospitals to recruit civilian physicians in critical specialties by offering the incoming physician his or her initial assignment of choice. We have used this program to increase our staff in vascular surgery, cardiology, family practice, and optometry. Three additional primary care physicians are expected to join us this summer.
- Creative use of Reserve Assets. The development of a close working relationship with our local reserve hospital (Tripler US Army Reserve Hospital (Augmentation)) has provided both an internal medicine consultant and gynecologist at our Schofield Barracks clinic, and the use of reserve personnel to fill Temporary Duty (TDY) and leave vacancies. Reserve physicians also accept deployment taskings, allowing our physicians to maintain continuity of care in the clinics.
- Memorandums of Agreement. Under negotiated agreements, the local Air Force clinic provides coverage in our weekend/holiday extended hours clinic, and the reserve hospital conducts monthly physical exams at Tripler.
- Use of Volunteers. Two civilian primary care physicians and an audiologist are working as Red Cross volunteers.
- Direct Health Care Provider Program. This program provides 24.5 full-time equivalent personnel in thirteen specialties and includes physicians, nurses, and medical technologists.
- We are the only Army facility currently seeing retirees for optometry care. Contract dollars, partially provided through an agreement with the Navy, have allowed us to hire an additional orthopedic surgeon. A contract recently let with a radiologist and radiology technician allowed us to reduce a long backlog for mammography examinations to same day appointments. We recently purchased six Phones for the Deaf, and have negotiated a contract to provide on-call language translation services. Both actions will improve access as well as patient accommodation, comfort, and satisfaction.
- Physical Plant Improvement. Mr. Chairman, I am happy to report to you that as a result of your support, a nine year construction/renovation project at Tripler is near completion. Despite the turmoil caused by this project, our productivity has grown each year, and we are proud to serve our patients in one of the very finest medical facilities in the world. For that we thank you very much.

RECAPTURING CHAMPUS WORKLOAD

In spite of productivity enhancements, the AMEDD has not kept pace with the growing beneficiary population's demand for health care. We are not using our medical treatment facilities to fully capacity. The most significant factor limiting full utilization is staffing. Consequently, when a patient's need cannot be accommodated within the direct care system, that patient is referred to the civilian sector under the CHAMPUS program. This alternative is more costly and generally not as acceptable to our beneficiaries as care in the direct system.

Initiatives described earlier which increase access to the direct care system also allow us to better use our existing capacity. Further, arrangements are established to control the movement of workload from Army hospitals to CHAMPUS.

At Tripler, we have opened an additional psychiatric ward and filled it with patients “reclaimed” from the CHAMPUS program. A team management approach by physicians, nurses and administrators has reduced our CHAMPUS non-availability statements by 32 percent, primarily in the areas of obstetrics and psychiatry.

INNOVATIVE MANAGEMENT PRACTICES

Innovation is the byword for the manner in which Army peacetime medicine is managed. The AMEDD welcomes the transfer of responsibility for funding CHAMPUS benefit claims, and fully supports the philosophy that medical treatment facilities (MTF) commanders be responsible for health services provided to their beneficiaries. Participation in managed health care initiatives such as the Catchment Area Management Demonstrations and the CHAMPUS Reform Initiative are proceeding. For the \$50 million in Alternative Use of CHAMPUS Funds Program, the Army has 20 projects approved for a \$2.4 million savings in fiscal year 1989. This equates to an annual savings of \$7.9 million.

Tripler Army Medical Center, as the only federal hospital in Hawaii, is at the center of the CHAMPUS Reform Initiative demonstration in our state. We now have over 3,000 enrollees. Health Care Finders are already located at Tripler, and we have begun negotiations with the contractor for personnel under the recently approved resource sharing guidelines. We hope to provide staffing in obstetrics, pediatrics, psychiatry, and neonatology using this program.

Innovation is also proving successful in direct patient care. Tripler's team approach to management, and resources provided by the AMEP, allowed us to open our 12th operating room, which in turn allowed us to better use existing capacity, to be more productive, and to reduce surgical backlog. Our orthopedic surgical cases increased from an average of 128 to 208 during the first month our additional operating room was open. Further, through careful preplanning, two United States Army Reserve (USAR) orthopedic surgeons accomplished 48 major surgical cases during their two week tour at Tripler. We have hired a utilization review nurse, whose function is critical to our efforts in providing quality care in the most efficient manner. During an average day at Tripler there are 70 admissions, 407 beds occupied, 9.5 live births, and 2,517 clinic visits. At 5.8 days, our average length of stay is well below the national average. The utilization review nurse has been a significant factor in reducing our beds occupied, length of stay, and number of long term patients.

Finally, Tripler is a test site for the Composite Health Care System (CHCS), a comprehensive, automated, integrated medical information system which will tie together clinical and administrative support throughout the medical center and our outlying clinics. We have implemented the outpatient pharmacy module of CHCS, and extended it to the clinics of all uniformed services throughout the island. Tripler Army Medical Center is the first hospital in DOD to incorporate other military services in this network. We urge your continued support for this extremely important system as it is further implemented throughout DOD medical facilities.

DOD-VA SHARING

Opportunities to share health resources and capabilities in VA and DOD facilities are being pursued under the Health Resources and Sharing Act. Cooperative ventures to fully use federal health facilities allow both systems to expand service availability while promoting cost containment. Since passage of this law, the AMEDD and the VA have successfully negotiated over 36 sharing agreements covering all aspects of hospital services.

Tripler's relationship with the VA in Hawaii began in 1931 and continues to be a cooperative and mutually supportive arrangement. Our current sharing agreement provides space available medical care for VA beneficiaries and the sharing of educational opportunities. On the average there are 34 VA inpatients at Tripler every day. They comprise 4% of our admissions and 8% of our beds occupied. We manage our VA patients under the Diagnostic Related Groups (DRG) methodology, and are reimbursed accordingly. Using this system we have reduced the length of stay for our VA patients by 40%.

RECRUITMENT AND RETENTION OF HEALTH CARE STAFF

The most pressing issue in the AMEDD is retention of our trained physician work force. Initial loss rates of our physician specialists have increased dramatically from fiscal year 1984 to the present. A recent report to Congress on management of military medicine suggests primary factors affecting physician retention are: professional job dissatisfaction; a perception of declining or inadequate resources, equipment, of facilities; excessive administrative duties; inadequate administrative and clinical support; and insufficient pay and compensation.

I discussed earlier many of the initiatives the AMEDD has undertaken to deal with these dissatisfiers. I also explained the role of medical centers in the recruit-

ment and retention of physicians. I now add a few words about pay and compensation.

In the fiscal year 1989 National Defense Authorization Act (Public Law 100-46, Sec. 612), Congress addressed the physician retention issue by authorizing DOD to pay a one time Medical Officer Retention Bonus (MORB) during fiscal year 1989. Initially there was great dissatisfaction with the MORB, due mostly to primary care specialists being deleted from the program. This group was later reinstated in the MORB; but the damage caused by the initial decision had already been reflected throughout the physician workforce, particularly in reduced numbers of Army physicians applying for training in primary care specialties. Initial feedback from the field concerning the reinstatement of 45 percent of the physician workforce for MORB eligibility is extremely favorable and should reduce earlier concern and dissatisfaction. It is essential that primary care specialists be included in the proposed fiscal year 1990 Medical Special Pay (MSP) plan.

Recruitment and retention of military and civilian registered nurses (RN) is an issue of serious concern to the AMEDD. There is a nationwide shortage of registered nurses, and the Army must compete for these increasingly scarce people within the entire military and civilian health care industry. It is difficult for us to match the civilian sector in size, range, and variety of inducements offered nurses, or in the speed with which they can implement their recruitment and retention strategies. An extensive nurse shortage action plan has been developed to resolve the shortage. Highlights of this plan include: increased recruiting emphasis by both the United States Army Recruiting Command and the ROTC Cadet Command; liberal granting of definite term extensions of service obligations; fully funding the Continuing Health Education Program for the Army Nurse Corps; changing accession policies designed to enhance recruiting, such as liberalizing age waivers; and other options currently under review.

CIVILIAN NURSES HAVE NOT BEEN FORGOTTEN

Initiatives are underway to enhance their recruitment and retention through special salary rate requests, granting of nationwide direct hire authority, funding for centralized paid advertising programs, conversion of selected supervisory military positions to civilians, and the development of other innovative career opportunities for civilians. There is still much to be done. Your support in these areas is essential to maintain the viability of our current military health care system.

Our last concern is in the area of other medical disciplines, both military and civilian, which comprise the support staff. These professionals, such as physical and occupational therapists, clinical psychologists, pharmacists, podiatrists, and others, are critical members of the health care team and are essential to the accessibility and delivery of quality patient care. Their shortage is a key dissatisfier of our physician staff. We anticipate problems in recruiting and retaining these individuals as we face a rapidly increasing demand in the civilian health care system. We are increasing our recruiting efforts in search for these specialists. A special study is reviewing the status of these disciplines; we anticipate results and subsequent recommendations will assist in recruiting these specialists.

CONCLUSION

The Army Medical Department is committed to providing quality health care to all our beneficiaries. Our medical centers stand at the heart of our health care delivery system. They make significant contributions to the recruitment and retention of health professionals, and their affiliations with our nation's universities and medical schools advance the art of medicine for all. The Army Medical Department, and Tripler Army Medical Center, face many challenges in improving access to the peacetime health care delivery system, reducing the cost of the CHAMPUS program, and recruiting and retaining a quality work force. We are dedicated to achieving these goals and have many initiatives in place or proposed in every area. With your continued assistance and support we will succeed.

Mr. Chairman, this concludes my prepared statement. I will be happy to answer any of your questions.

BIOGRAPHICAL SKETCH

Major General Girard Seitter III, Commanding General, Tripler Army Medical Center, was born in Philadelphia, Pennsylvania on 2 January 1935. He was commissioned a second lieutenant, Infantry, through the Reserve Officer Training Corps at Gettysburg College where he graduated in 1957 with a Bachelor of Arts degree in

biology. He was awarded his doctor of medicine degree from Hahnemann Medical College, Philadelphia, in 1962.

He completed his internship at Philadelphia General Hospital, after which he entered active Army duty and served as a battalion surgeon and medical platoon leader with the 5th Infantry Division (Mech). He then completed residencies in both general surgery and cardiothoracic surgery at Brooke Army Medical Center.

Prior to assuming command of Tripler Army Medical Center, General Seitter was Vice Commander, Joint Military Medical Command, Randolph AFB, Texas.

General Seitter served in a variety of other assignments prior to his most recent duties. He served as Chief of General Surgery Service and Assistant Chief of the Department of Surgery at Walson Army Hospital, Fort Dix, New Jersey. He served as the Assistant Chief of Cardiothoracic Surgery at Brooke Army Medical Center. He was Division Surgeon with the 8th Infantry Division and later, VII Corps Surgeon. Following his tour in Europe, he commanded the Medical Department Activity at West Point with dual responsibility as Surgeon for the United States Military Academy.

Other key assignments include Commander, 8th Medical Command (Provisional) and United States Army Community Hospital-Seoul with additional responsibility as Surgeon, United States Forces Korea and Eighth United States Army; duty as Special Assistant to The Surgeon General, and later as Director of Health Care Operations, Office of The Surgeon General; and Commander, Brooke Army Medical Center.

He is a graduate of the AMEDD basic and advanced courses, the Army Command and General Staff College (graduated on the Commandant's List), the U.S. Army War College and the Program for Senior Managers in Government at Harvard University.

He is a fellow of the American College of Surgeons and the American College of Chest Physicians. He is certified by the American Board of Medical Examiners, the American Board of Surgery, and the American Board of Cardiothoracic Surgery.

Awards and decorations which General Seitter has received include the Legion of Merit (with two Oak Leaf Clusters) and the Meritorious Service Medal (with three Oak Leaf Clusters). He also earned the Parachute Badge and the Expert Field Medical Badge.

General Seitter is currently Vice Chair (Flag Officer) for the Hawaii State Chapter, American Red Cross.

General Seitter is married to the former Margaret S. (Peggy) Sinnott. They have four children, Girard, Christine, Kathleen, and Margaret.

Senator INOUE. I thank you very much, General.

Having spent over 24 months of my adult life in military hospitals here and there, my interest in the quality of care and availability of care is much more than just being casual.

BROOKE ARMY MEDICAL CENTER BURN CENTER

I would like to begin my questioning on a matter not related to Tripler—at least not directly—but related to your old command at Brooke General Hospital. It would be an understatement to tell you that some of us were surprised and shocked when we learned that DOD decided to phase out the burn center at Brooke Medical Center.

The burn center has had international recognition. It played an important role in helping those who were involved in the aborted mission to rescue the Iran hostages. It is now playing an important role in improving relations with the Soviet Union by sending teams to help those who were involved in the recent train debacle. You have played a major role in helping those who were injured in the *Starke* and *Iowa*.

If I am not mistaken, it is the only burn center in the United States. What is the reason?

REASON FOR PHASING OUT BURN CENTER

General SEITTER. Sir, two comments before I answer that, Senator. First, it is the only military burn center in the United States; there are other civilian centers. Interestingly enough, many of the people who man, staff, and operate those civilian centers were trained at the Institute of Surgical Research, otherwise known as the burn center, at Brooke Army Medical Center.

Senator, in the past 3 or 4 years there has been considerable turmoil, discussion, and debate over the size and mission of Brooke Army Medical Center. Suffice it to say that Brooke Army Medical Center has recently been authorized \$273 million by our Congress for us to build a new hospital, a replacement facility, of 450 beds.

A decision has been made that the burn center laboratory building would not be included in that new construction. Forty burn beds are included in the new Brooke Army Medical Center. I would submit to you that any hospital can have 40 burn beds, but only the combination of a clinical laboratory in support of that burn section and a clinical research laboratory in support of the entire program constitutes a burn center or an Institute of Surgical Research.

To my knowledge, Senator, there has not been a statement by Department of Defense eliminating the burn center. But by not including the clinical research laboratory and the clinical laboratory in support of the 40 beds, in effect we have emasculated our burn center.

You asked why have we done that. My understanding is fiscal. The cost of the burn unit, the estimated cost, will be \$12.9 million. It is my understanding that for an additional \$12.9 million we could have our research laboratory colocated with and, in fact, in the newly constructed hospital facility at Brooke Army Medical Center.

I would also say to you, sir, that that is the Army Surgeon General's first priority for medical military construction.

Senator INOUE. I realize that this is in the Military Construction Subcommittee, but we are concerned in this subcommittee about providing the best care for our men and women, and for the life of me, with a budget of nearly \$300 billion, we would in the name of budgetary responsibility of \$12.9 million do away with a facility that has helped thousands of men and women, many of them overseas. I can assure you that as one member of this Congress we will do everything possible to see that it is reinstated.

In other words, as a result of the decision to do away with the facilities in the Milcon request, essentially you have done away with the burn center. Without the clinic, the labs, you do not have a burn center?

General SEITTER. That is correct, sir.

Now what I do not know is what the future plan would be in terms of future construction. It would make some sense to me that the building be accomplished now together with the new Brooke Army Medical Center.

Senator INOUE. I would gather that the team, if I may call the doctors and nurses and specialists that Brooke Army Medical

Center has been able to gather as a result of this burn center, will disperse once these facilities are not available?

General SEITTER. Sir, it will not have the academic attraction, it will not have the professional meaning, it will not be the productive medical, clinical, and academic center that it is today.

Let me tell you, Senator, that professors of major medical schools in our country—when we had a draft, especially in a time of war—recommend their very top physicians come to the Institute of Surgical Research at Brooke Army Medical Center.

WORLDWIDE IMPACT OF BURN CENTER

Sir, we have produced 33 directors of civilian burn centers throughout the country and 17 other active staff directors. Other countries that have established burn centers with our alumni of the Brooke Army Medical Center burn center include three in Belgium, three in Jordan, one in Pakistan, one in Norway, and one in Israel.

Senator INOUE. If we do away with the burn center as recommended by this Milcon request, who will do the research on the trauma and the effects of battlefield burns and injuries, NIH? NIH is going to do this?

General SEITTER. Sir, right now the burn work is being done in a very dilapidated, deteriorated laboratory facility which is under threat of failing reaccreditation and requires a new facility. I believe the thought is that burn research can proceed in that old facility at the present. In the very near future, however, that will clearly be an inadequate facility, it will become inadequate to the point of being discredited, and then I cannot tell you what the plan for burn research, either clinical or academic, will be.

I do not know what the plan is.

NURSING SHORTAGE

Senator INOUE. You have mentioned it; other witnesses have given us the same story about the dangerous shortage of nurses. Do you have any suggestions as to what we can do to alleviate this problem?

General SEITTER. Yes, sir. Senator, the shortage of nurses has always been one that we have looked to in the future and that we would deal with that in the future. The future is now. We had a budget end strength in fiscal year 1988 of 4,965 nurses. In fact, at the end of that fiscal year, end of September 1988, we had 4,552 nurses on active duty, and the projection over the next 3 years will be approaching 4,000.

At this point we are critically short of registered nurses as well as licensed practical nurses and other assistants.

There are a number of initiatives, sir, that have been taken. One, an increased recruiting activity by both the ROTC cadet command as well as the Army Recruiting Command. We have established additional positions for nurse recruiting and, incidentally, that has been successful. We have seen successes in those areas.

An additional method of improvement are some legislative issues that have been introduced. One is your bill, Senate bill 131, which asks for a release under the Defense Officer Management Person-

nel Act [DOPMA] of field grade nurses. Another is a special pay incentive, bonus pay, for nurses. And one is a bill which addresses loan repayment: an extension of loan repayment and raising the ceiling for loans to graduate nurses. There are other initiatives, such as discussion of a Federal nursing school.

THREE ACTIONS TAKEN ON RECRUITMENT AND RETENTION

If we look back, Senator, at the issue and problem of physician recruiting and retention, we did three things in general, not all at once, certainly, but each one has had its impact upon physician retention and recruitment.

One was a Federal university, the Uniformed Services University of the Health Sciences. Another was special pay bonuses and compensation. We will never match pay scales for physicians in the civilian sector; however, the few dollars that have been increased over the number of years have had a significant impact on physician retention.

The other factor, Senator, is job satisfaction, and that is physicians who stay in the Army feel very clearly that they are making a contribution and that they are comfortable in doing what they are doing.

I only bring up physician retention and recruitment to say that if there is any logic in those things that we have done for physician retention and recruitment, it seems to me that there is logic in doing the same or at least approaching the issue of nursing shortages in a similar manner.

These are all things that are being considered. These are all things that are being worked by the three services and Department of Defense—the possibility of a Federal nursing school, the possibility of pay bonuses, and improving what I will call job satisfaction for nurses.

PHYSICIANS' LACK OF ADMINISTRATIVE SUPPORT

Senator INOUE. During the past year, I have conducted a study of poll-taking, admittedly unprofessional, by inquiring of physicians of what they consider to be the highest priority. And surprisingly, many of them and the vast majority of them responded by telling me that it was not the pay. Their problem was the lack of support. As they pointed out dramatically, they say, "Here I am with a dozen years of professional training with no secretary or support personnel, and I spend over half of my time doing clerical work, filing, looking through scheduling lists when someone else could be doing that and I could be using my professional talent to serve the patients."

And as one of them indicated to me he is quitting because he just had an offer, the pay itself was much better than what the military could provide. But, he said, "I have three secretaries, and all I am expected to do is professional work." Am I getting the real word from the professional group?

General SEITTER. Sir, I believe so. I believe that is an accurate assessment across the board of comments I have also heard and that are being made known to the Surgeon Generals of all three services. Budget end strength of personnel, ceilings, and inability to

recruit and retain our paraprofessional people has, in fact, created a situation where our physicians and our nurses feel they have an overburdening of administrative duties, duties that detract from their time in direct patient care.

Senator, I would tell you that one of the things I have found to be very positive in military medicine is the opportunity to serve in command and staff positions. One may think of a hospital commander as an administrator. Whether that be right or wrong is not the question. The point is that each of us have some administrative duties even in the civilian world; physicians in the civilian world have administrative duties.

Having said that, there are excessive burdens placed on our physicians in the military today because of lack of clerks, because of lack of attendants, even chaperones. Physicians have to go out in the hallway and find people to come into a room to chaperone examinations. I am not exaggerating. We are working with that. We are trying to overcome that.

ARMY MEDICAL ENHANCEMENT PROGRAM

Some of the initiatives, Senator, that the Army Medical Department with the help of Congress has undertaken, include the Army Medical Enhancement Program. This is a program where with increased funding we have been able to hire additional people. One of the things that we have done at Tripler Army Medical Center is to make access better for our patients by hiring folks to do some of the administrative work, to make the experience in the medical center, in the hospital easier, and for the physician to be able to concentrate on his technical skills and on those things that he must accomplish with his patient.

The job dissatisfier is becoming more and more of an issue with military physicians all the time. Pay and compensation will always be there. But in my professional lifetime I have seen that come down to the third or fourth reason that people now get out. And the first is that which you mention, job satisfaction.

LACK OF SUPPORT STAFF

Senator INOUE. The military budget has been often times described as being bloated and too large. It may be so, but I can assure you as chairman of the Defense Appropriations Subcommittee, it is not bloated in the medical side of this massive budget. In fact, civilian medical organizations, the AMA and such, have suggested that, for optimum efficiency, the ratio of support staff to physicians should be eight support to one physician.

In many locations in the military the ratio is one support for three physicians. The lack of support staff, as both of us have suggested, has been the major irritant to our military doctors. In fact, in the flag ship of all military hospitals—I have been told that Walter Reed is the flag ship—they do not have a 1-to-1 ratio. Yet in the civilian sector, for optimum efficiency they are talking about 8-to-1.

I think that something has to be done to cure this problem. At least discuss it. And I am embarrassed to tell you that we have been negligent in that area. We will try to do our amends.

JOINT MILITARY MEDICAL COMMAND

Now if I may bring up another matter. I am asking many questions that do not relate to Tripler because I wanted someone at your level to discuss with us the problem that you see in the hospital segment of our medical system providing to our men and women.

In your biography you have served as Commander of Brooke Army Medical Center and as Vice Commander of the Joint Military Medical Command, and both of them in the San Antonio area.

Some in your profession have looked with some skepticism on the Joint Military Medical Command. I have been advised that whenever there are two medical facilities located in close proximity they form this joint command. In the case of San Antonio, you have Brooke and—what is the other one there—Wilford, isn't it?

General SEITTER. Yes, sir; Wilford Hall Air Force Medical Center.

Senator INOUE. One of the initiatives taken by the Command was to send the psychiatric section to Wilford.

General SEITTER. Yes, sir.

Senator INOUE. So Brooke has no psychiatric facilities?

General SEITTER. No inpatient psychiatric care; that is correct.

Senator INOUE. So all the services will have to send theirs to Wilford?

General SEITTER. That is correct.

Senator INOUE. I was also told that while Brooke is an old and crowded teaching hospital, Wilford Hall is much newer and is underutilized. Is it underutilized?

General SEITTER. Sir, Wilford Hall was built in the 1950's for 1,000 beds, designed for 1,000 beds. In fact, if I am correct, it has never been staffed at 1,000 beds. And with today's requirement for size and sophistication of equipment and for administrative offices and requirements, the operational size of Wilford Hall is about 700 beds.

One can argue if we build 1,000 beds and only have 700 beds now, it is underutilized. That may not be fair in that, as I said, all hospitals today have had to give up space, some clinical space in the interest of equipment and administrative requirements.

Senator INOUE. As a participant in this Joint Command, do you think it should be continued or discontinued?

JMMC CONCEIVED ON THREE PREMISES

General SEITTER. Sir, the Joint Military Medical Command in San Antonio was conceived, I believe, on three premises. One, that consolidation and amalgamation of resources would prove to be economically efficient and together with that, that we could provide better care. Two, that the Army and the Air Force did not work well together. Three, that Brooke Army Medical Center would be downsized to some level lower than what it is today, a major medical center.

Let me address them in reverse order. The first is that Brooke Army Medical Center now will be a 450-bed medical center. It will be equitable to, if not equal to, what it is today: A few less beds, but it will be a full service medical center with all the missions of a medical center.

The next issue is the cooperation and the relationship between the Air Force and the Army. Mr. Chairman I have been associated with Brooke Army Medical Center directly and indirectly for over 25 years. I was a general medical officer there. I served 6 tough years as a surgical resident, completing both general surgery and cardiothoracic residencies. I was later called back as the assistant chief of cardiothoracic surgery, our open heart program. I later commanded Brooke Army Medical Center. And then, finally, in the Joint Military Medical Command, had oversight of Brooke Army Medical Center together with Wilford Hall.

I am happy to be on the record to tell you that I have never been associated with a medical community that worked better together than Brooke Army Medical Center, Wilford Hall Air Force Center, and the civilian community, particularly the University of Texas Health Science Center in San Antonio. That triangle of academic and clinical medicine is superb.

AMALGAMATION AND CONSOLIDATION

The third issue and the first that I mentioned to you, is amalgamation and consolidation. There are two major areas, sir, that we have addressed in the Joint Medical Command. One was the amalgamation of clinical teaching programs, our residency programs. The other was the economies that could be achieved through bulk purchasing of items like X-ray films and pharmaceuticals.

I think we have shown that we have made some progress in bulk purchasing. In the past we purchased for Brooke Army Medical Center and independently for Wilford Hall. It makes some sense to consolidate those and to purchase one large lot. And then we in the medical command or the two medical centers would make distribution. How much savings, sir? I have been gone for over a year and I do not know what those savings are.

The other area I mentioned was consolidation of graduate medical education. To answer that that has been a success or a failure belies the complexity of the issue. Let me give you an example, addressing three of our teaching programs—urology, cardiology, and pathology. In urology, after we combined the two programs at Wilford Hall and Brooke, we had a follow-on residency review committee: a civilian committee that must come in and accredit our program. Our individuals practitioners, as you know, are licensed and certified, our programs are accredited.

The urology residency review committee found that the amalgamation of Brooke and Wilford Hall residency programs in urology produced one of the finest programs in the entire country in urology—a success. On the other hand, pathology at Wilford Hall had been previously discredited. Brooke Army Medical Center, on the other hand, has a fully accredited program. Were we to amalgamate and combine pathology programs at Wilford Hall and Brooke, the one that was discredited has the very real potential and probability of dragging down both programs.

And the third one that I mentioned is cardiology. That is a wash. They are both excellent. And neither the Joint Military Medical Command, nor working individually, will influence either of those programs.

Senator INOUE. When the psychiatric section was sent to Wilford Hall, am I correct to assume that Army physicians were also assigned to Wilford Hall?

General SEITTER. Yes, sir; they were. We were trying to do that as easily and with as little inconvenience as possible. Let me go back again and remind you that was done in the days when Brooke Army Medical Center was to be downsized to 200 beds and to eliminate many of the internal medicine and psychiatry services at Brooke. Brooke was to be an intense 200-bed surgical hospital. And the movement of the psychiatry inpatient services was the first of many to move from Brooke to Wilford Hall.

There were many growing pains, many difficulties, and I will tell you it was not well accepted by our patient population

TRUST TERRITORY PATIENT REFERRALS

Senator INOUE. You have every reason to be proud of the residency training program at Tripler. And I understand that the—part of the residency training is supported by patients that are brought in from other Pacific areas?

General SEITTER. Yes, sir.

Senator INOUE. Such as Samoa. I further understand that because of present regulations, local governments like Samoa would be required to pay for the treatment of patients at Tripler and, as a result, some of these governments are choosing to send their patients to other less expensive locations such as the Philippines, thereby threatening your residency training program. Is my observation correct?

General SEITTER. Sir, let me qualify that. Any medical center welcomes the complex cases. No one wishes ill for any one, but if a patient is sick and needs to be taken care of, we like to do that. Having said that, our residency programs are in good shape. We have a good patient population. But our cardiologist, for instance, went to one of the trust territories just recently and found in less than 1 week 13 children that had such advanced rheumatic heart disease that this cardiologist basically certified them for the need of surgical intervention, heart valve replacements primarily.

These are 13 children that would benefit from a humanitarian point of view and would provide us at Tripler excellent teaching cases. Urology, cardiology, general surgery, obstetrics/gynecology: the same situation. We will survive without them. We would love to have them if we could get them.

Senator INOUE. But right now the trust territory would have to pay for this?

General SEITTER. That is correct.

Senator INOUE. Some of them just cannot afford this. Are you interested in being able to forgive payment for the treatment in a selected number of patients who have the special problems which would enhance your residency training program?

General SEITTER. Yes, sir. The requirement for reimbursement and for nonbeneficiary patients to reimburse the Government is a sound policy. We should not dispense free care. However, there is a humanitarian role. There is a need for these people to receive care.

They are in the need and we are capable and ready to provide that help.

We would welcome those and on a limited basis, and we could provide that care on a waived reimbursement basis.

Senator INOUE. I think that we do have a special obligation. Our relationship is not a sovereign and a sovereign in the usual sense. The trust territories became our responsibility as a result of United Nations action. Samoa is our possession, and they are nationals. We do have special compacts and treaties with the new emerging countries in Micronesia.

So I think there is some authorization involved. I will suppose that the cost that you would like to absorb would be the transportation costs. It is a rather high tab. I think it is about, what, \$2,000 round trip?

General SEITTER. Yes, sir, at least. Of course, it depends where they are coming from. That is a tough one for us to meet. That is a tough obligation. We can provide the medical care, having the patient arrive. We even have some space to provide some quartering. But transportation is a very difficult obligation for us to meet.

CHAMPUS REFORM INITIATIVE

Senator INOUE. Tripler is a key player in the CHAMPUS reform initiative in Hawaii and in California. And if I may, will you submit to the committee a memo telling us how you are progressing in this area? I would like to know how this reform initiative is working out.

General SEITTER. Yes, sir. Sir, if I may, I would like to tell you that in general we are happy with the progress. There were three areas of problems. One, local advertising; two, resource sharing; and three, payment of reimbursement of physician and health care provider payment. Let me summarize by telling you that all three of those have been addressed either locally or by Department of Defense and the contractor.

All three of them are being worked. And all three have time lines and have either seen progress or there is predictable progress in the future. Tripler Army Medical Center is happy and proud to be part of that demonstration program. And we see a bright future for it.

With your permission, Mr. Chairman, I would like to provide additional information for the record.

[The information follows:]

CHAMPUS REFORM INITIATIVE

CHAMPUS Reform Initiative [CRI] is making excellent progress in Hawaii, and Tripler Army Medical Center is proud to be a part of this demonstration project. Initial problems were in three areas: local advertising, resource sharing, and claims payment. All have been addressed at both the local and Department of Defense levels and good progress is evident in each area. Specifically,

—Local advertising of the CRI Program has increased dramatically. Over 3,500 brochures have been handed out by CRI personnel at local post exchanges. Twenty thousand brochures were mailed to eligible beneficiaries. Over 7,300 beneficiaries have attended 131 information briefings. Specific information was sent to the top 500 high dollar standard CHAMPUS users. Intensive print, radio, and television advertisements have continued the marketing effort. The success of these efforts is apparent in the increased enrollment of

the CHAMPUS Prime portion of CRI. To date 4,292 beneficiaries have enrolled. This is 571 above projections.

- Recent inclusion of resource sharing in the CRI Program will allow the contractor to hire providers who will work in our facility thereby increasing access for patients, providing care in the lowest cost setting, and returning workload from civilian facilities. Tripler and our local contractor are in agreement on maximizing the use of resource sharing. We will soon sign an agreement for 12 pediatric registered nurses and 6 licensed practical nurses, which will allow us to open a third pediatric ward. There are seven other areas where we are negotiating resource sharing agreements, and we plan to convert our five present partnership agreements to resource sharing agreements.
- The problem of claims payment is being vigorously addressed with the Prime contractor by the Department of Defense. The local contractor has quickly interceded in situations where a partnership physician was going to leave because of slow payments. All indications are that the Prime contractor is resolving this problem.

The goals of CHAMPUS Reform Initiative—increasing access, decreasing CHAMPUS costs, and recapturing of CHAMPUS workload, are being met in Hawaii. CRI provides access through a comprehensive network of 457 providers throughout all islands. There are 12 network hospitals, 4 of them on Oahu, and partnership physicians see hundreds of patients each month in our facility. The addition of resource sharing will soon expand our bed capacity in pediatrics, obstetrics, and psychiatry.

The rates charged CHAMPUS patients by network providers are less than 70% of the prevailing rates. Tripler has decreased CHAMPUS Nonavailability Statements by 50% in our obstetrics and psychiatry departments. The increased competitive environment generated locally has spurred the development of several look-alike CRI Programs by other health care organizations. These competitors are further reducing copayments and pushing down overall costs in order to attract beneficiaries. Tripler's success in recapturing CHAMPUS workload has led to recent discussions with the local contractor as their providers begin to experience the results of increased competition.

Quality of care is improved due to increased communication between Tripler and the local contractor. Tripler co-sponsored with the local contractor an Open House for network providers, giving them an opportunity to learn more about Tripler with a briefing, followed by a tour with their specialty counterparts. A system to facilitate case management has been established which allows Tripler, as well as civilian facilities, to discharge patients to appropriate, cost effective, home or outpatient services. Tripler meets regularly with the contractor to share information and resolve problems, especially in the areas of access and quality care.

CHAMPUS Reform Initiative is doing very well in Hawaii. Tripler Army Medical Center is committed to the success of this important program and together with the local contractor we are moving ahead with all goals. This program has a bright future in providing quality care to more and more beneficiaries at a reduced cost to the Federal government.

PHYSICIAN RETENTION

Senator INOUE. My final question, sir. We have discussed the nursing shortage. I noticed according to the charts the rise in physician loss, especially specialists, increased dramatically since 1984.

General SEITTER. Yes, sir.

Senator INOUE. Up until 1984 it was not a problem. But since 1984 it has just shot sky high. Why is 1984 so important? What happened in the 1984 period that caused all of these physicians to suddenly decide to leave?

General SEITTER. Sir, I cannot answer that.

Senator INOUE. You say that it was the pay difference?

General SEITTER. There was a great clamor, a great perception on the part of our primary health care physicians that there was inequitable and discriminatory action with the recent pay and compensation bills. That has come to a focus over the last year. I cannot testify to back to 1984, sir. I can get those figures.

[The information follows:]

RETENTION RATES

Shown below are the Medical Corps retention rates since fiscal year 1984:

Fiscal year:	[In percent]
1984.....	72.6
1985.....	63.9
1986.....	46.3
1987.....	41.5
1988.....	41.0

These rates reflect physician retention at their initial decision point which usually occurs at the end of their training obligation.

General SEITTER. But I can tell you that the medical officer retention bonus in 1988 did not recognize our primary physicians, our emergency room physicians, outpatient care physicians, psychiatry, and pediatricians. As a result, we expected significant backlash in exodus of our physicians. And I will be happy to provide for the record through the Army Surgeon General figures which compare the MORB acceptance rates for each physician group.

[The information follows:]

MORB ACCEPTANCE

Shown below are the numbers and percentages of physician by groups who have accepted the MORB as of 12 May 1989:

Specialty	Eligibles	Accepted	Taker percentage
Group 1.....	268	61	23
General Surgery 9			
Neurosurgery			
Orthopedic Surgery			
Plastic Surgery			
Thoracic Surgery			
Vascular Surgery			
Group 2.....	180	42	23
Anesthesiology			
ENT			
Ophthalmology			
Urology			
Group 3.....	232	43	18
Radiology			
Nuclear Medicine			
OB/GYN			
Group 4.....	106	38	36
Cardiology			
Child Cardiology			
Dermatology			
Group 5.....	289	65	22

Specialty	Eligibles	Accepted	Taker percentage
Acad Int Med			
Allergy/Immun.			
Clinical Pharm			
Critical Care			
Emergency Med.			
Endocrinology			
Gastroenterology			
Geriatrics			
Hematology/Oncology			
Infectious Disease			
Nephrology			
Oncology			
Pulmonary			
Rheumatology			
Group 6.....	545	13	2
Pediatric Subspec.			
Flight Surgeon			
General Int. Med.			
Neurology			
Child neurology			
Occupational Med			
Pathology			
Preventive Medicine			
Psychiatry			
Child Psychiatry			
Group 7.....	236	3	1
Family Practice			
Gen Pediatrics			
Physical Medicine			
Total.....	1,856	265	14

Groups 6 and 7 were initially excluded from MORB; thus, the low acceptance rate as compared to all other groups.

Senator INOUE. I would like to have that because that story has been relayed to me by several physicians. Apparently, it affected relationships among physicians, and the morale factor was deteriorating.

General SEITTER. Absolutely. Senator, I have had surgeons come to me and say that they would be willing—and I have to accept this for what it is worth; I believe them—to take less in their bonus if the primary care physicians could receive something in order to keep the team intact. With the inclusion this year of our pediatricians, obstetricians, and primary care physicians, there has been a renewed positive attitude. And we are seeing less of those categories of physicians leaving.

The one comment that I made about pay compensation in my opening statement to you dealt with exactly that. And that would be, Senator, to implore the Congress of the United States and Department of Defense to look seriously at an equitable, an understandable and a dependable pay compensation package for all physicians. We understand that we cannot compete, that the country will not compete, with the outside civilian sector.

But to provide compensation for one group and not the other, especially when the other had it at one time, is perceived as a very severe discriminator. Our people will, and have gotten out because of it.

Senator INOUE. And all of us who consider ourselves to be professional hate to be told that we are not as good as the next fellow.

General SEITTER. Sir, that is absolutely correct.

Senator INOUE. I can imagine what would happen if Members of the House got more pay than Senators or vice versa. I think we would have another civil war here.

I thank you very much, General Seitter. It has been a pleasure to have you here with us this afternoon, and I look forward to continuing to work with you in the future.

It is just not possible for this subcommittee to call upon all of the hospital commanders. Not because I am from Hawaii that I decided to call upon the commanding officer of Tripler, but Tripler has many features not readily seen in other areas. It is an all-service hospital for one thing. It takes into consideration several clinics. It has foreign policy implications in its work. It is a residency hospital, et cetera, et cetera.

And with your background and your involvement at Brooke, I thought that you would be an ideal witness for our purposes. So we will be looking upon you and Tripler to represent all other medical hospitals. Walter Reed is not too happy over this.

General SEITTER. Mr. Chairman, thank you. I am very proud and privileged to have had the opportunity to testify with your committee. Thank you, sir.

Senator INOUE. Thank you very much, sir.

OPTOMETRY

STATEMENT OF COL. JOHN T. LEDDY, CHIEF OF ARMY OPTOMETRY

Senator INOUE. And now our next witness is Col. John T. Leddy, Chief of Army Optometry. Colonel Leddy is also Assistant Chief of Medical Service Corps and a consultant for optometry to the Surgeon General of the Army.

Optometry is a primary eye care specialty in the armed services. The vision care of over 90 percent of active duty personnel is managed by optometrists. Optometry plays a vital role in readiness preparation; new sophisticated technological devices provide an unprecedented demand for optometric services. For example, increasing use of night vision goggles and ballistic and laser eye protection require the services of highly trained eye care specialists.

In a war setting, optometrists are deployed with the troops to assure that soldiers needing eye care and replacement glasses can be attended and returned to duty in a minimum of time. Colonel Leddy, we will be interested to have your comments on the important role of optometry in the armed services. We have received your prepared statement, and I can assure you that it will be made part of the record.

But, as a preface, may I tell you this, for several years I found myself having difficulty with my left eye. And I must have gone to several eye specialists, ophthalmologists and such. The only thing that they told me was that I need more exercise. Well it took an optometrist to look into my eye ball and say that you have a retinal occlusion. So as far as I am concerned, you fellows are professionals. You did something that the ophthalmologists could not do for me.

Please proceed sir.

Colonel LEDDY. Good afternoon, Mr. Chairman. I am Colonel John Leddy, Chief of Army Optometry, Assistant Chief of the Medical Service Corps, Consultant to the Surgeon General in Optometry.

I have over 32 years active duty of which 30 years has been as an optometrist. I have served in assignments worldwide and I have been a consultant to the Army Surgeon General since 1983. I must add that my Army career terminates on July 31, 1989. That is my mandatory retirement.

Senator INOUE. You mean you are quitting now?

Colonel LEDDY. Unfortunately, sir, they only give you 30 years and I have completed my 30.

ROLE OF MILITARY OPTOMETRISTS

Military optometrists have responsibility for the visual welfare of active duty personnel, their dependents, and all other eligible beneficiaries. It is the responsibility of service optometrists to keep the active duty personnel in a combat-ready posture. This means optometry has to assure commanders their active duty personnel have the best vision plus their required optical appliances which includes spectacles, gas mask inserts, eye-protective devices, and contact lenses.

Military optometrists go to war. We are assigned to combat divisions and support the division troops. This means optometrists are deployed as far forward as the field commanders desire. For example, in Vietnam optometry officers were deployed with the troops, even had mobile capability, and could assure commanders that troops needing vision care and replacement eye wear could be fabricated within a few hours if the situation called for this.

This proved to be one of the most effective combat multipliers available. The same situation of need for eye wear in World War II meant that anyone requiring vision services had to be evacuated to the rear, and was, therefore, effectively lost to his unit permanently.

SIGNIFICANCE OF SERVICES TO BATTLE COMMANDERS

- Let me explain the significance of optometric services to battle commanders.

Leutenant General Mittermeyer while serving in Vietnam as a battalion surgeon stated, and I quote:

Optometric capability within a division has been without doubt, the most significant single advance in division level medical service since the addition of TO&E helicopters for medevac purposes. Its effect on conserving the foxhole strength within the division has been significant and it has also favorably effected the flood of congressional inquiries which we used to receive in reference to glasses problems.

Optometry is a bonafide go-to-war profession. The services provided are necessary, even critical to our fighting forces. This has been proven time and time again.

NEED CRITICAL

But today, Army optometry, in fact, all of uniform service optometry, is experiencing difficulty in recruiting and retaining optom-

etrists. In my case, Army optometry is authorized 220 individuals. We have today assigned 138. This critical shortage has necessitated the curtailment of services to retirees and retiree dependents. This curtailment has been going on for almost 2 years now.

This critical shortage has also resulted in some bases having no optometric services available. For instance, Alaska has had no optometrist assigned and has not had one since 1 December 1988. Similar instances are Fort Monmouth, NJ, has none; Fort Devens has none, and we have four clinics in Germany that have none.

We have basic training centers in the United States which are in dire need of optometrists. Bases such as Fort Sill are authorized four; Fort Sill has one. Fort Benning, another training center operated until recently with only one optometrist where three were authorized. These shortages necessitate curtailment of care and treatment to all but active duty. And even the active duty personnel are denied timely care in some instances.

Shortages of this magnitude significantly affect combat readiness. Troops requiring spectacles, gas mask inserts, ballistic laser eye protection, and contact lenses are forced to wait an inordinate amount of time for an appointment for this eye wear. The officers we have are working excessive hours, and still they can in no way make up for the shortages present. And there is more pressure for the future.

These dedicated, hard-working optometrists are going to bear the brunt of increased demand for their services. With the fielding of the ballistic laser eye protection, all active duty military personnel will wear these devices. The first issue of these are designated for selected Army and Marine divisions.

Another additional mission requirement is fitting the AH-64 Apache helicopter pilots with contact lenses; 22 percent of the AH-64 pilots require spectacle corrections. In the Air Force, about 27 percent of all pilots and 52 percent of all navigators require spectacle corrections. In the Navy, the percentage is similar for pilots, but their back seaters are 90 percent spectacle wearers.

With the development of new technology and the avionics required, it is necessary to fit these spectacle wearers with contact lenses. This means that there is an added requirement for more optometric manpower. Contact lenses require multiple clinic visits versus a single visit for the issuance of a pair of glasses.

The critical shortage of optometrists is of grave concern to me. Without incentives, it is unlikely that the necessary optometric manpower can be recruited. The Navy and Air Force optometry consultants share my concern, since they have similar problems. In fact, none of the services met their procurement goals for this year for optometrists. There simply are no incentives to come into the service.

HEALTH PROFESSIONAL SCHOLARSHIP PROGRAM

In the past, we had great success in procuring optometrists through the Armed Forces Health Professional Scholarship Program, the HPSP Program. This was the single best procurement tool the Army ever had. However, it did nothing to address the retention problem. While HPSP was the answer for our procurement,

of the last class of HPSP graduates, assessed in 1984—they ended the program in 1980—the service obligation was up in 1988, less than 2 percent of these remain on active duty. Overall, about 5 percent remain on active duty past their second tour.

HPSP, no longer available to optometry, is not a retention incentive. Currently there are no retention incentives. While optometry is one of four health professions which now receive special pay, the amount, \$100 a month, is viewed as tokenism. This amount has proved to be ineffective in either recruiting or retaining optometry officers.

Optometry has not been looked at in about a decade. Only recently DOD reviewed optometry and in this draft study concluded a recruitment bonus as well as realistic special pay were necessary to induce optometrists to a military career. I am convinced that without a realistic bonus pay program, optometry will continue to decline in numbers, which will adversely impact on the combat readiness of our troops.

The young optometrists are in a bind, attempting to pay back expensive student loans which usually come due after 3 years' service. These loans average in excess of \$34,000 and a young officer is hard pressed to meet this loan obligation on his service pay. Pay in the private sector is almost double, year for year, what the military can offer. In the face of this, it is understandable why we cannot recruit or retain optometry officers.

It is given that there is a requirement for optometrists. Optometric services are necessary for combat readiness. To recruit and retain these scarce health care providers we have to be more competitive with the market place. It is imperative that incentives be given for procurement and the special pay must be augmented to retain these valuable officers.

Mr. Chairman I thank you for the opportunity to appear before you today. I stand ready to answer your questions.

OPTOMETRISTS BONUS PAY

Senator INOUE. You indicated that the bonus received is looked upon as a tokenism and it is unrealistic. What would you consider to be a realistic bonus?

Colonel LEDDY. In order to make it more realistic for the people today that are coming in with \$34,000 average debt, I feel that we would have to offer a bonus, just to come in, from \$5,000 to \$6,000. Plus their pay, their monthly bonus pay would have to be up to a minimum of \$500.

Senator INOUE. General Seitter, if I may ask, am I correct that physician bonus ranges from about \$5,000 to \$50,000?

General SEITTER. I believe the top figure is \$45,000. There are five different bonuses. The latest is the medical officer retention bonus. There are five different ones. Depending on one's eligibility and length of service, the maximum that one can receive is \$45,000.

Senator INOUE. And what sort of MD's would receive the minimum, \$5,000?

General SEITTER. Sir, with the elimination of the primary physicians under the medical officer retention bonus [MORB], it would be the primary physician, pediatrician, and the obstetrician.

Senator INOUE. Colonel Leddy, whatever it is, you feel that \$100 is unrealistic; even doubling that would be unrealistic.

Colonel LEDDY. I certainly feel it would not help at all, sir. Today optometrists can come right out of school and enter private practice making \$15,000 to \$20,000 more than we can offer them. We have had them come in ready to sign on the dotted line and within a day say, "I am sorry, I cannot come, I have been offered a job offering me \$20,000 more than you have offered me."

Senator INOUE. During the fiscal year 1989 defense appropriations bill consideration we placed report language and recommended that each of the services should establish a separate service of optometry similar to that established at Tripler Army Medical Center. As you may know, the Senate language was accepted by the Congress. Is this program progressing?

Colonel LEDDY. Sir, I am happy to say that this program—and I want to thank you for your leadership in helping to establish it. The one at Tripler—I have the final draft report on my desk. I might add in glowing terminology it is, I think, an outstanding success. It has impacted upon the morale of all active duty optometrists, not just at Tripler, because it gives the optometrists a purpose it would appear.

He can now control his own destiny. He has his own service in which he can be an equal partner of the team. I think it is a remarkable transformation. It has been a burr in the saddle of optometrists for over 25 years. I think it would be fantastic if we could have this established at all of our MTF's, pull us out from under the Department of Surgery, in which we have no need to be, and put it under the Department of Outpatient Care.

It is a beautiful transformation that is occurring at Tripler.

OPTOMETRIST AUTHORIZATIONS

Senator INOUE. Today we have 138 optometrists in the Army?

Colonel LEDDY. Yes, sir.

Senator INOUE. And you are authorized to have 220?

Colonel LEDDY. Yes, sir.

Senator INOUE. If nothing is done, you predict that the numbers will get worse?

Colonel LEDDY. It is going to get worse, sir.

Senator INOUE. What rank is the highest in the optometric service?

Colonel LEDDY. It is my rank, sir, O-6.

Senator INOUE. There is no brigadier general?

Colonel LEDDY. No, sir. There is one brigadier general in the Medical Service Corps, of which we are a part, but it is not likely that an optometrist would ever be the Chief of the Corps.

Senator INOUE. Nurses have a general now.

Colonel LEDDY. Yes, sir.

Senator INOUE. Do you think it is about time the optometrists got a general, too?

Colonel LEDDY. It would be a welcomed addition.

Senator INOUE. Let's see what we can do about it.
Colonel LEDDY. Thank you.

CONTINUING EDUCATION

Senator INOUE. Is it necessary for members of your profession to attend continuing education courses?

Colonel LEDDY. Yes, sir; 50 States require continuing education in order to renew your license. In order for us to maintain a commission, we have to have an up-to-date State license from one of the 50 States or territories. And so we have to abide by the regulation of the State.

I am licensed to practice in Virginia. Virginia requires me to have 20 hours of continuing education per year in order to renew my license.

Senator INOUE. Who pays for this when you are in active duty?

Colonel LEDDY. In most instances, sir, it is paid by the Government. The Army gives us TDY. In all cases, that is not the case. There are instances where an MTF might not have enough funds in order to fund someone to go. If he is in an isolated area, he may not be granted that and he has to pay that himself. There is no guarantee he will be given TDY funds to go to this.

Senator INOUE. Is there a requirement for continuing education among the Physician Corps?

General SEITTER. Absolutely, sir.

Senator INOUE. Who pays for the education among the doctors, MD's?

General SEITTER. We have TDY funds. Not all physicians get to go because of ceilings and constraints. The priority for TDY for continuing health education is to the physicians.

Senator INOUE. Well, thank you very much. You are the first optometrist to appear before us to testify. I think your service is very important. Maybe I am biased because I wear glasses. But it takes more than two arms and two legs. If you do not have eyes to see, we can not carry out our missions. So your profession is very important to us, and I thank you very much.

Colonel LEDDY. Thank you sir.

Senator INOUE. Your presentation obviously will be of great value to us as we continue our consideration of health care for our armed services. May I wish you every success and happiness in the future. Are you going to retire or go into private practice?

Colonel LEDDY. That is debatable sir. I will probably practice somewhere in the area.

Senator INOUE. I think you are too young to retire. I have to say this because I am going to be a senior citizen myself.

SUBCOMMITTEE RECESS

The subcommittee will stand in recess until Thursday, June 22 at 2 p.m. At that time we will hear testimony from the Hon. Richard Cheney, the Secretary of Defense.

[Whereupon, at 4:49 p.m. Tuesday, June 20, the subcommittee was recessed to reconvene at the call of the Chair.]

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